MEDICAL PROCEEDINGS

MEDIESE BYDRAES

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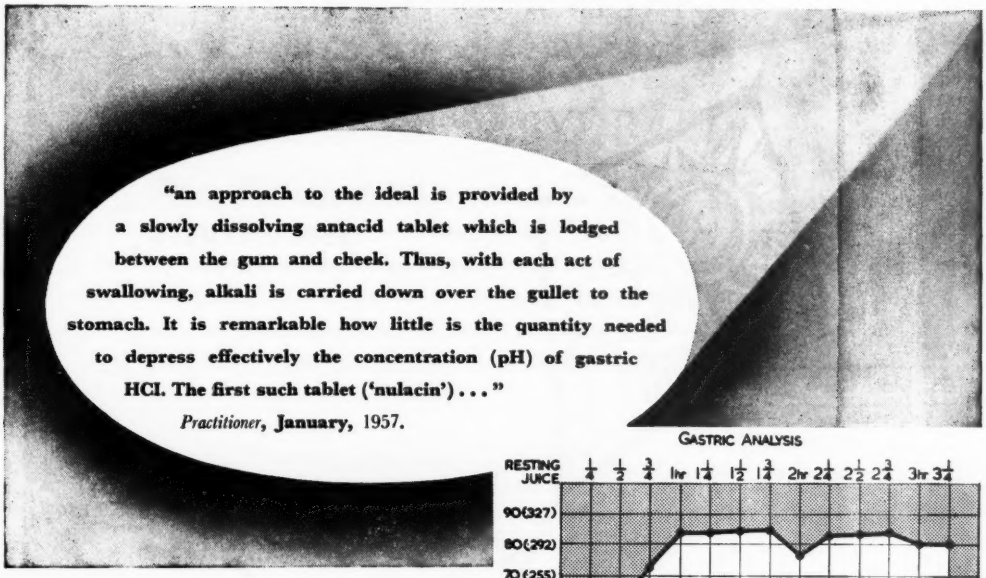

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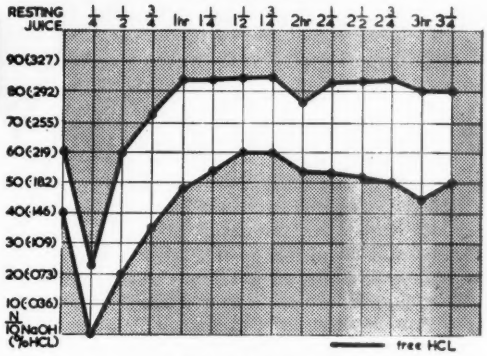

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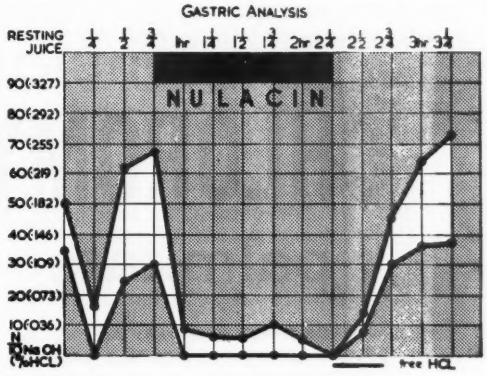

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BIBLIOGRAPHY

Antacids, *The Practitioner*, January, 1957, **178**: 43

Antacids in Peptic Ulcer, *The Practitioner*, January, 1956, **176**: 103

Recent Advances in the Ulcerative Diseases of the Gastro-intestinal Tract. *Amer. J. Gastro.*, December, 1956, **26**: 665

Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, *Amer. J Dig. Dis.*, March, 1955, **22**: 67-71

Management of Peptic Ulceration in General Practice, *Med. World*, December, 1954, **81**: 591-601

Clinical Investigation into the Action of Antacids, *The Practitioner*, July, 1954, **173**: 46.

Further Studies on the Reduction of Gastric Acidity, *Brit. Med. J.*, 23rd January, 1954, **1**: 183-184

Control of Gastric Acidity by a New Way of Antacid Administration, *J. Lab. Clin. Med.*, 1953, **42**: 955

The Effect on Gastric Acidity of "Nulacin "Tablets, *Med. J. Aust.*, 28th November, 1953, **2**: 823-824

Discussion on Peptic Ulceration, *Proc. Roy. Soc. Med.*, May, 1953, **46**: 354

Medical Treatment of Peptic Ulcer, *Med. Press*, 27th February, 1952, **227**: 195-199

The Control of Gastric Acidity, *Brit. Med. J.*, 26th July, 1952, **2**: 180-182

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H. A. Shapiro, B.A., Ph.D., M.B., Ch.B., F.R.S.S.Af.

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EDITORIAL · REDAKSIONEEL

THE MARCH MEETING OF THE MEDICAL COUNCIL

With every 5-year election there is inevitably a change in the composition of the Council. There is, neverthelesss, especially when constructive matters have been decided by the Council, an obligation on the new Council to observe the commitments entered into on its behalf by the previous Council. The moral force of this duty is very great, especially in matters of policy.

The new Council's failure to follow this practice on certain occasions at its recent meeting may have created a certain amount of obscurity about its intentions and we therefore draw attention, for this reason amongst others, to certain features of the March meeting.

PROFESSIONAL APPOINTMENTS TO BODIES, SOCIETIES OR ORGANIZATIONS PROVIDING MEDICAL SERVICES

PROPOSED RULE 19(*ter*) OF THE MEDICAL COUNCIL'S ETHICAL RULES

This Rule (as adopted by the Council at its meeting in September 1958) read:

'1. A medical practitioner or dentist who has accepted a professional appointment to any Body, Society or Organization providing medical or dental services, may be required to answer to the Council for any act or omission in providing such services or for any act performed by or on behalf of such Body, Society or Organization, which may appear to the Council to be such as would, if occurring in ordinary medical or dental practice, constitute improper or disgraceful conduct.'

DIE MAART-VERGADERING VAN DIE GENEESKUNDIGE RAAD

Met iedere 5-jarige verkiesing vind daar onvermydelike veranderings in die samestelling van die Raad plaas. Desondanks—en veral wanneer opbouende besluite oor sake van belang deur die ou Raad geneem is—rus daar 'n verantwoordelikheid op die nuwe Raad om die verpligtinge wat die uittredende Raad in sy naam aangegaan het, na te kom. Die morele krag wat deur hierdie plig uitgeoefen word, is baie groot, veral vir sover dit beleidsake betref.

Die nuwe Raad se versuim om hierdie gebruik by sekere geleenthede op sy onlangse vergadering te volg, het waarskynlik aanleiding gegee tot 'n sekere mate van onsekerheid oor sy bedoelinge, en om hierdie rede, onder meer, wil ons die aandag op sekere kenmerke van die Maart-vergadering vestig.

PROFESSIONELE AANSTELLINGS IN LIGGAME, VERENIGINGS OF ORGANISASIES WAT MEDIESE DIENSTE BESKIKBAAR STEL

VOORGESTELDE REËL 19(*ter*) VAN DIE GENEESKUNDIGE RAAD SE ETIESE REËLS

Hierdie Reël (soos goedgekeur deur die Raad op sy vergadering in September 1958) lui soos volg:

‚1. Van 'n mediese praktisyn of 'n tandarts wat 'n professionele aanstelling aanvaar tot enige Liggaam, Vereniging of Organisasie wat mediese of tandheelkundige dienste beskikbaar stel, kan daar verlang word om verantwoording aan die Raad te doen van enige daad of versuim by die verskaffing van sodanige dienste, of van enige daad verrig deur of namens sodanige Liggaam, Vereniging

We pointed out at the time[1] that the adoption of this rule implemented a profoundly important principle first advocated in the Council by Dr. Maurice Shapiro several years before. The rule had the effect of bringing medical practitioners employed by lay organizations (and hence, in fact, the organizations themselves) squarely within the scope of the Council's ethical rules.

It was, however, not quite clear at the time whether the rule (in the form in which it was approved by the Council) was *intra vires* the regulations which could be promulgated under the Medical, Dental and Pharmacy Act.

The outgoing Council therefore decided to seek legal opinion on the matter. If the opinion was to the effect that the proposed rule was *intra vires,* the rule was to be promulgated.

It appeared at the March meeting that the legal opinion was to the effect that Rule 19 (*ter*) could not validly be promulgated with the existing powers at the disposal of the Council. The Council therefore, on a simple resolution, decided that 'the matter be not proceeded with.'

The previous Council's desire and intention about the implementation of the principle involved could not been stated more explicitly than it was expressed in the proposed rule. As the existing powers were not adequate for the purpose, it is strongly urged that the Council seek an amendment of the Act along the lines of Section 76, whereby the objective can be attained.

This is all the more obligatory on the present Council because (already as far back as 1954) it was realized that the position might not be met except by specific amendment of the principal Act. The Council *at that time* resolved that if legal opinion indicated that the Council was not competent to deal with the position by having rules promulgated, 'the Executive Committee be empowered to investigate the best means of providing *statutory power to implement the principles approved in the proposed rules.*' (Italics inserted).

For the practice of pharmacy the analogous position has in fact been safeguarded by a specific provision in the principal Act (Section 76) and in the light of the legal advice tendered to the Council it seems clear that the next step should not have been a decision not to proceed with the matter, but a decision to implement the clearly expressed intention of

1. Editorial (1958): This Journal, **4**, 716.

of Organisasie wat, as dit in 'n gewone mediese of tandheelkundige praktyk verrig was, volgens die mening van die Raad op onbehoorlike of laakbare gedrag sou neerkom.'

Ons het destyds daarop gewys[1] dat die aanvaarding van hierdie reël uitvoering gee aan 'n uiters belangrike beginsel wat etlike jare tevore deur dr. Maurice Shapiro vir oorweging aan die Raad voorgelê is. Die effek van die reël was om mediese praktisyns wat in die diens van leke-organisasies staan (en gevolglik ook die organisasies self) geheel en al binne die bestek van die Raad se etiese reëls te bring.

Destyds was dit egter nie heeltemal duidelik nie of die reël (in die vorm waarin dit deur die Raad goedgekeur is) *intra vires* die regulasies was wat kragtens die Wet op Geneeshere, Tandartse en Aptekers afgekondig kon word.

Die uittredende Raad het gevolglik besluit om 'n regsmening oor die saak in te win. Indien die geraadpleegde advokaat die mening sou uitspreek dat die voorgestelde reël *intra vires* was, was die Raad van plan om die reël af te kondig.

Op die Maart-vergadering het geblyk dat die regsmening was dat Reël 19(*ter*), met die oog op die huidige bevoegdhede van die Raad, nie regtens afgekondig kon word nie. Na die indiening van 'n eenvoudige mosie het die Raad dus besluit dat ‚daar nie met die saak voortgegaan word nie.'

Die vorige Raad se strewe en doel in verband met die uitvoering van die beginsel wat by die saak betrokke is, kon nie duideliker gestel gewees het as wat in die voorgestelde reël uiteengesit is nie. Aangesien die huidige bevoegdhede nie voldoende vir die beoogde doel is nie, word daar baie sterk aan die hand gedoen dat die Raad 'n wysiging van die Wet (op die grondslag neergelê in artikel 76) moet probeer bewerkstellig sodat die genoemde oogmerk bereik kan word.

Die plig wat in hierdie verband op die huidige Raad rus, is des te groter omdat daar reeds sedert 1954 besef word dat daar waarskynlik net een manier is om die posisie die hoof te bied, nl. deur 'n spesifieke wysiging van die hoofwet. Die Raad het *destyds al* besluit dat as regsgeleerdes die mening uitspreek dat die Raad nie bevoegd is om die saak aan te pak deur die afkondiging van reëls nie, die Uitvoerende Komitee gemagtig moet word om ondersoek in te stel na die beste manier om *statutêre bevoegdheid te verkry vir die uitvoering van die beginsels wat in die voorgestelde reëls neergelê word.* (Ons kursivering.)

Wat die apteekwese betref, is die analoë posisie inderdaad reeds beveilig deur 'n spesi-

1. Redaksioneel (1958): Hierdie Tydskrif, **4**, 716.

the Council, even if this required an amendment to the principal Act.

The intention of the proposed rule is to protect medical practitioners employed by corporate bodies from being placed in a situation where their conduct may be brought into question through some act of omission or commission by their employers—a situation over which the Council at present has no control.

CLOSED PANELS TO BENEFIT SOCIETIES

In this matter the Council adopted the view:

1. That the principle of freedom of choice in medical practice is the ideal.
2. That membership of a closed panel is not *per se* an unethical act provided that the conduct of such a practitioner at all times conforms to the ethical requirements laid down by the Council.

The Council has never at any time expressed itself as opposed to closed panels. Moreover the endorsement of the principle of freedom of choice in medical practice can only be described as an endorsement of a very considerable glimpse of the obvious. The Report of the Special Ad Hoc Committee which considered the matter at some length, detailed the possible abuses affecting both the public and the profession which might result unless safeguards were introduced to prevent them. In this Report (which the Council considered when dealing with this matter) the following views were expressed:

CLOSED PANEL APPOINTMENTS TO BENEFIT SOCIETIES IN RELATION TO MEDICAL ETHICS

'In its deliberations on *Bodies Corporate in Relation to Medical Ethics*, the Council accepted in principle that the system of private medical and dental practice was desirable and its preservation necessary in South Africa. While it is universally recognized that the "insurance" principle is a wholesome development for the provision of medical and dental services to the public, it is the duty of the Council to ensure by way of ethical rules that this development proceeds in a manner which will safeguard the traditional ethical relationship between practitioner and patient.

The principal features of closed-panel appointments to benefit societies which may be regarded as being contrary to medical ethics or detrimental to the honour and interests of the medical and dental professions in their relationships with the public are:

1. Limitation of choice of practitioner by the individual patient.
2. The diversion of patients from the practitioners of their own choice to practitioners appointed by the societies.
3. Compulsory membership of a benefit society as a condition of employment in particular trades, industries and undertakings. This frequently includes not only the employed person but also his family.

fieke bepaling in die hoofwet (Artikel 76), en in die lig van die regsmening wat nou aan die Raad voorgelê is, skyn dit duidelik te wees dat die volgende stap nie 'n besluit moes gewees het om nie met die saak voort te gaan nie, maar wel 'n besluit om uitvoering te gee aan die duidelik uitgedrukte bedoeling van die Raad, selfs al vereis dit ook 'n wysiging van die hoofwet.

Die bedoeling van die voorgestelde reël is om te verhinder dat mediese praktisyns wat in die diens van verenigde liggame staan in 'n posisie geplaas word waar hul gedrag in verdenking kom ten gevolge van hul werkgewers se sondes van versuim of bedryf—'n toestand waaroor die Raad op die oomblik geen beheer het nie.

GESLOTE NAAMROLLE VIR BYSTANDSVERENIGINGS

Wat hierdie saak betref, het die Raad die volgende menings uitgespreek:

1. Dat die beginsel van vryheid van keuse in die mediese praktyk die ideale beginsel is.
2. Dat lidmaatskap van 'n geslote naamrol *per se* nie oneties is nie, met dien verstande dat die gedrag van so 'n praktisyn te alle tye aan die etiese vereistes van die Raad voldoen.

Die Raad het nog nooit die mening uitgespreek dat hy teen geslote naamrolle is nie. Temeer, die bekragtiging van die beginsel van vryheid van keuse in die mediese praktyk kan slegs beskryf word as die bekragtiging van iets wat baie duidelik voor die hand lê. In die Verslag van die Spesiale Ad Hoc-komitee wat taamlik breedvoerig op die saak ingegaan het, word daar 'n uiteensetting gegee van moontlike misbruike wat sowel die publiek as die professie kan affekteer tensy stappe gedoen word om hierdie soort misbruike te voorkom. In hierdie Verslag (wat deur die Raad oorweeg is toe hy op die onderhawige saak ingegaan het) word die volgende menings uitgespreek:

GESLOTE NAAMROL-AANSTELLINGS VIR BYSTANDSVERENIGINGS EN DIE MEDIESE ETIEK

In sy beraadslagings oor *Verenigde Liggame en Hul Verband met die Mediese Etiek* het die Raad in beginsel toegestem dat die stelsel van private mediese en tandheelkundige praktyke wenslik, en dat die behoud daarvan noodsaaklik in Suid-Afrika is. Terwyl daar allerweë erken word dat die „versekeringsbeginsel" 'n gesonde ontwikkeling is vir sover dit dit beskikbaarstelling van mediese en tandheelkundige dienste aan die publiek betref, is dit die plig van die Raad om deur middel van etiese reëls te verseker dat hierdie ontwikkeling voortgesit word op 'n wyse wat die tradisionele etiese verhoudinge tussen die praktisyn en sy pasiënt beveilig.

Die vernaamste kenmerke van geslote naamrolaanstellings vir bystandsverenigings wat bes moontlik beskou kan word as strydig met die mediese etiek of nadelig vir die eer en belange van mediese en tandheelkundige praktisyns in hul verhoudinge tot die publiek, kan soos volg saamgevat word:

„1. Die beperking van die keuse van 'n praktisyn deur die individuele pasiënt.

4. The abuse of the functions of the appointed practitioners as certificating officers for the purpose of disciplining employees in industry and commerce in such matters as sick leave and other benefits.

5. The breaches of professional secrecy which flow inevitably from (4) above.

6. Restrictions imposed on professional officers of the society regarding the scope and nature of medical and dental services to be made available to members of the society and the threat to the standards of professional care which such restrictions may imply.

7. Exploitation of the professional appointees (and through them of the profession as a whole) in return for ready-made practices which the benefit societies are able to offer to the holders of the appointments. The per-service remuneration in certain benefit societies has been calculated to be considerably less than would be assessed under the provisions of Section 80(*bis*) of the Act as reasonable.

8. Abuses which flow from the acceptance by practitioners of over-large appointments, or multiple appointments, involving the care of more patients than any individual practitioner can reasonably expect to serve. Such monopolistic practices tend to inferior service to the patients by the appointed practitioners, to farming out of the work to assistants, and to the sale of portions of the monopolies in the form of partnerships.

9. In a situation in which lay committees and secretaries of benefit societies determine professional appointments, it is inevitable that such appointments should on occasions be made with little regard to merit. Canvassing for appointments and nepotism in the selection of appointees tends to undermine the dignity of the profession and the purposes of the ethical rules. It has become generally accepted as a fact that many, if not most, closed-panel appointments to benefit societies are filled before they are advertised, the advertisement itself being a mere formality to safeguard the successful candidate in terms of the Council's ethical rules. In the result, those whose self-respect and ethical standards are highest are not infrequently left behind in the scramble for appointments.

10. The subservience of professional appointees to lay secretaries and committees in control of the society's affairs tends to lead to a situation in which the maintenance of the goodwill of those in control may take precedence over the individual interest of the patients.

11. Resentment by patients against the imposition of doctors other than those of their choice (whose services they may be compelled to call on if only for the purposes of certification) leads to an intolerant attitude and unreasonable demands for services by the patients and may be reciprocated in the form of an unsatisfactory attitude towards the patients on the part of the practitioners.'

It was never the intention or the desire of the Council to make closed panel appointments unethical *per se*. Indeed, the propriety of such appointments was never in question; it was the system (and the abuses it might lead to) that was under scrutiny. The Council's rider, therefore, that the practitioner must conform to the ethical rules of the Council is a pious expression which is not helpful in dealing with the numerous situations which, the Ad Hoc Committee pointed out, could arise.

2. Die afwending van pasiënte van praktisyns wat deur hulself gekies is na praktisyns wat deur die verenigings aangewys word.

3. Verpligte lidmaatskap van 'n bystandsvereniging as 'n voorwaarde vir indiensneming in besondere beroepe, nywerhede en ondernemings. Dit sluit dikwels nie alleen die werknemer in nie, maar ook sy familie.

4. Die misbruik van die funksies van die aangestelde praktisyns as sertifiseringsamptenare met die doel om handels- en nywerheidswerkers te dissiplineer wat sulke aangeleenthede soos siekte-verlof en ander voordele betref.

5. Die oortreding van die reël i.v.m. professionele geheimhouding wat onvermydelik uit (4) hierbo voortspruit.

6. Die beperkings wat op professionele amptenare van die vereniging gelê word wat betref die omvang en die aard van die mediese en tandheelkundige dienste wat tot beskikking van die lede van die vereniging gestel word, en die gevaar wat sodanige beperkings vir die gehalte van professionele behandeling meebring.

7. Die uitbuiting van die professionele persone wat aangestel word (en, deur hulle, ook die uitbuiting van die professie as 'n geheel) terwille van die ‚klaargemaakte' praktyke wat die bystandsverenigings aan die aangesteldes kan bied. Daar word bereken dat die per-diens-vergoeding in sekere bystandsverenigings aansienlik minder as dié wat kragtens die bepalings van Artikel 80(*bis*) van die Wet as redelik beskou kan word.

8. Die misbruike voortvloeiende uit die aanvaarding deur mediese praktisyns van aanstellings wat te groot is, of van veelvoudige aanstellings wat die behandeling van meer pasiënte meebring as wat redelikerwys deur enige enkele geneesheer behandel kan word. Sodanige monopolistiese praktyke kan uitloop op die minderwaardige behandeling van die pasiënt deur die aangestelde praktisyn, op die oordrag van die werk aan assistente, en op die verkoop van gedeeltes van die monopolie in die vorm van 'n vennootskap.

9. In 'n toestand waar leke-komitees en sekretarisse van bystandsverenigings oor professionele aanstellings besluit, is dit onvermydelik dat sodanige aanstellings by wyle sal geskied met min inagneming van werklike verdienste. Stemwerwery vir aanstelling en nepotisme by die keuse van die persone wat benoem gaan word, het 'n neiging om die waardigheid van die professie en die oogmerke van die etiese reëls te ondermyn. Daar word vandag allerweë erken dat baie en miskien selfs die meeste geslote naamrol-aanstellings vir bystandsverenigings gevul is nog voordat hulle geadverteer word. Die advertensie self is net 'n blote formaliteit om die suksesvolle kandidaat te beskerm kragtens die Raad se etiese reëls. Die gevolg is dat diegene met die meeste selfrespek en die hoogste etiese standaarde dikwels agtergelaat word in die aanstellingswedren.

10. Die onderdanigheid van professionele persone wat aangestel word aan die leke-sekretarisse en komitees wat die vereniging se sake bestuur kan bes moontlik aanleiding gee tot 'n toestand waar die instandhouding van die welwillendheid van diegene wat aan die hoof van sake staan, swaarder weeg as die belange van individuele pasiënte.

11. Die gebelgdheid van pasiënte oor die afdwing op hulle van ander geneeshere as dié wat deur hulself gekies is (van wie se dienste hulle miskien verplig sal word om gebruik te maak, al is dit dan net vir sertifiseringsdoeleindes) gee aanleiding tot 'n onverdraagsame houding en onredelike eise deur pasiënte, met die gevolg dat die praktisyn ook 'n

The Council has not defined the ethical requirements with which the practitioner must conform and has thus neglected to formulate the ethical rules designed to prevent specific abuses, actual and potential, which were adumbrated in the Report of the Ad Hoc Committee. The task imposed on the present Council by its predecessor was to decide whether, and if so, in what way these potential abuses could be prevented by ethical rules. The March resolution takes the matter no further and it seems to us highly desirable that the Council should apply itself to the matter and ensure that the necessary provisions are promulgated.

RULES UNDER WHICH SPECIALISTS MAY PRACTISE

The consideration of this important aspect of the practice of medicine goes back to as far as March 1956, when the Council, after giving consideration to a report of a Special Ad Hoc Committee on the registration of specialists or consultants reported:

(*a*) That the statutory registration of specialists be maintained but that rules be drafted to place certain restrictions on the actions of specialists in an attempt to remove some of the causes of friction between specialists and general practitioners, in the interest of both these classes of medical practitioners and also of the public.

(*b*) That the principles to be adopted in drafting the rules be:

i. Specialists shall not do domiciliary visiting, except when requested to do so by a general practitioner;

ii. That if a specialist becomes cognizant of the fact that the patient has a general practitioner, it is incumbent on him to report to the general practitioner;

iii. That it is incumbent on a specialist to refer the patient to his general practitioner for treatment which is customarily administered by a general practitioner, and in this connexion the specialist must satisfy himself as to whether the patient has a general practitioner treating him; if he is satisfied that the patient is not under the treatment of a general practitioner he may continue to treat the patient himself and he may also continue to treat the patient if he is requested to do so by the general practitioner;

iv. That it shall be incumbent on a specialist to ascertain from a patient who comes to him direct whether or not the patient has a general practitioner;

v. That a general practitioner shall not prevent a patient from going to a specialist of his choice, provided he is selecting the right type of specialist.

A resolution to exempt specialist obstetricians was rejected and the principles involved were not departed from in a further report of the Ad Hoc Committee presented to the Council. The Council has not defined the ethical requirements with which the practitioner must conform and has thus neglected to formulate the ethical rules designed to prevent specific abuses, actual and potential, which were adumbrated in the Report of the Ad Hoc Committee. The task imposed on the present Council by its predecessor was to decide whether, and if so, in what way these potential abuses could be prevented by ethical rules. The March resolution takes the matter no further and it seems to us highly desirable that the Council should apply itself to the matter and ensure that the necessary provisions are promulgated.

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A resolution to exempt specialist obstetricians was rejected and the principles involved were not departed from in a further report of the Ad Hoc Committee presented to the Council.

DIE REËLS WAARKRAGTENS SPESIALISTE KAN PRAKTISEER

Die oorweging van hierdie belangrike aspek van die geneeskundige praktyk gaan reeds sover terug as Maart 1956 toe die Raad, na die bestudering van 'n verslag van 'n Spesiale Ad Hoc-komitee oor die registrasie van spesialiste en konsulterende artse, soos volg gerapporteer het:

(*a*) Dat die statutêre registrasie van spesialiste gehandhaaf word, maar dat reëls opgestel moet word om sekere beperkings op die optrede van spesialiste te plaas in 'n poging om sommige van die oorsake van wrywing tussen spesialiste en algemene praktisyns in die belang van albei hierdie soorte mediese praktisyns en ook in die belang van die publiek uit die weg te ruim.

(*b*) Dat, by die opstel van die reëls, die volgende beginsels aanvaar moet word:

i. Spesialiste moet nie huisbesoek doen behalwe wanneer hulle deur 'n algemene praktisyn gevra word om sulks te doen nie;

ii. Dat indien 'n spesialis bewus word van die feit dat 'n pasiënt 'n algemene praktisyn het, dit sy plig is om verslag aan die algemene praktisyn te doen;

iii. Dat dit die plig van die spesialis is om 'n pasiënt na sy algemene praktisyn te verwys vir die soort behandeling wat gewoonlik deur 'n algemene praktisyn toegepas word. In hierdie verband moet die spesialis hom tevrede stel of die pasiënt wel 'n algemene praktisyn het wat hom behandel. Indien hy tevrede is dat die pasiënt nie deur 'n algemene praktisyn behandel word nie, kan hy voortgaan om die pasiënt self te behandel, en hy kan ook voortgaan om die pasiënt self te behandel indien hy deur die algemene praktisyn versoek word om sulks te doen.

iv. Dat dit die plig van die spesialis is om uit te vind van 'n pasiënt wat regstreeks na hom gekom het of so 'n pasiënt 'n algemene praktisyn het al dan nie.

v. Dat 'n algemene praktisyn 'n pasiënt nie moet verhinder om na 'n spesialis van sy eie keuse te

cil at its meeting in September 1958.[2] We pointed out at the time that the only remaining obstruction to the promulgation of the rules enshrining the principles adopted by the Council was delay in the legal formulation of these rules. The outgoing Council specifically instructed the Executive Committee to bring the matter to finality subject to consultation with the Council's legal advisers.

In view of these firm instructions it is disconcerting to find that the decision to bring the matter to finality has not been pursued. Despite the vehement protests voiced by Dr. P. F. H. Wagner, it would seem that the whole issue has been thrown back into the melting pot. The vast majority of the profession, i.e. the very considerable number of general practioners, has an intimate interest in the encroachment of specialists in the legitimate field of general practice. This it was the intention of the proposed rules to control. The principles previously agreed upon by the Council vitally affect and protect the pattern and the quality of medical practice in this country.

During the past decade these and other matters have received diligent and encouraging attention from the Council. It is to be hoped that the monumental achievements of the past 10 years will not lightly be abandoned but will serve as achievements which the new Council will seek to consolidate and to emulate.

gaan nie, met dien verstande dat die pasiënt die regte soort spesialis gekies het.

'n Mosie vir die vrystelling van spesialis-verloskundiges is verwerp, en van die beginsels wat by die saak betrokke is, is daar nie afgewyk in 'n verdere verslag van die Ad Hoc-komitee wat aan die Raad op sy vergadering in September 1958 voorgelê is nie.[2] On het destyds daarop gewys dat die enigste oorblywende struikelblok in die weg van die afkondiging van die reëls vir die vaslegging van die beginsels wat deur die Raad aanvaar is, die vertraging is wat met die regsformulering van hierdie beginsels gepaard gaan. Die uittredende Raad het die Uitvoerende Komitee spesifiek gelas om die saak tot finaliteit te bring, onderhewig aan oorlegpleging met die Raad se regsadviseurs.

Met die oog op hierdie vaste opdrag is dit verontrustend om te vind dat geen vordering gemaak is met die besluit om die saak tot finaliteit te bring nie. Ondanks die kwaai proteste van dr. P. F. H. Wagner skyn dit asof die hele aangeleentheid weer eens in die smeltkroes te lande gekom het. Die oorgrote meerderheid dokters, d.w.s. 'n baie aansienlike aantal algemene praktisyns, het intieme belang by die inbreuk wat spesialiste op die gewettigde gebied van die algemene praktyk maak. Die doel van die voorgestelde reëls was om dit te kontroleer. Die beginsels waaroor die Raad in die verlede ooreengekom het, raak en beskerm die patroon en die kwaliteit van die mediese praktyk in hierdie land op 'n uiters belangrike wyse.

Gedurende die afgelope dekade het die Raad sorgvuldige en bemoedigende aandag aan hierdie en ander aangeleenthede bestee. Daar word gehoop dat daar nie sommer liggies van die monumentale prestasies van die afgelope 10 jaar afgesien sal word nie, maar dat hulle inderdaad sal dien as prestasies wat die nuwe Raad sal probeer om te konsolideer en na te boots.

MEDICO-LEGAL SECTION

PARTNERSHIPS AND BARRING CLAUSES

IN THE SUPREME COURT OF SOUTH AFRICA (WITWATERSRAND LOCAL DIVISION)

IN THE MATTER BETWEEN E. L. F. (*First Applicant*), R. G. H. (*Second Applicant*), G. K. (*Third Applicant*) and B. S. H. (*Respondent*)

Claasen, J.: This is an application for an order restraining the Respondent from practising or being interested in any medical practice, other than in full time employment of the Central, Provincial or Local authorities, either directly or indirectly in Johannesburg for a period of five years as from the 1st day of February, 1959.

The parties hereto are all registered medical practitioners and have been in general medical practice together as partners in terms of an agreement of partnership. It is clear that this is a very lucrative practice. The practice was commenced by the first applicant and he was subsequently joined by the other partners. Each one on being admitted paid a substantial sum for the privilege of becoming a partner. On retirement from the partnership it also seems clear that such a retiring partner would have to be paid out a very substantial sum as his share of the goodwill of the partnership. After due notice by the Respondent he retired from the partnership during January, 1959. He thereupon became entitled to be paid out his share of the goodwill of the partnership. This amount, when determined, will apparently be a considerable sum.

2. Editorial (1958): This Journal, **4**, 720.

2. Redaksioneel (1958): Hierdie Tydskrif, **4**, 720.

By virtue of the deed of partnership a retiring partner became bound by a restraint covenant in the following terms

'20. The partner retiring by notice or arbitration if awarded Goodwill undertakes in consideration of the said Goodwill, not to practise or be interested in any medical practice other than in full time employment of the Central, Provincial or Local Authorities or as a Specialist or Consultant, either directly or indirectly in Johannesburg for a period of five years from the date of termination.'

Agreements in restraint of trade are in general contrary to public policy and often declared by the Courts to be void.

Many of these contracts are quite reasonable and contain nothing contrary to public policy. It is quite a common occurrence in a partnership where a partner is bought out by the remaining partners to introduce a reasonable restraint against competition by the retiring partner. An unreasonable restraint being an inroad on individual liberty of action in trading is void as being against public policy. A reasonable one is not. In each case the Court will take all the circumstances into account. It will look at the nature and the extent of the restraint, the nature and the extent of the interests to be protected and the relationship between the parties at the time of entering into the agreement. After taking into account all such relevant circumstances the Court will decide whether the restraint is reasonable or not in the interests of the parties and the general public.

Until the Respondent retired from the partnership the parties kept consulting rooms in the Southern Suburbs and also in the City. Thereafter the remaining partners continued to have these consulting rooms. About 90 per centum of their patients reside in the Southern Suburbs.

Immediately after the termination of the partnership the Respondent set himself up in general medical practice in the Southern Suburbs in competition with the applicants and in breach of the restrictive covenant he is doing damage to their goodwill. It is not denied that the applicants are suffering irreparable harm.

In the restrictive covenant only full time employment by the Central, Provincial and Local Authorities is referred to. From the affidavits filed it is clear that there are many full time posts available for medical practitioners, with bodies such as hospitals, mining concerns, insurance companies and others. The respondent admits that the restraint is reasonable both as to area and time for the protection of the goodwill of the applicants. But he further contends that the restraint is unreasonably wide and therefore he is not bound to carry it out. He contends that it is too wide, because he is prohibited from taking full time employment with bodies and concerns other than the Government, the Province or the Municipality.

The Respondent does not say that it is his intention to take employment with any of these bodies or concerns, but that such employment would fall within the ambit of the restriction and further that such employment would not compete with the applicants' practice and, therefore the restrictive covenant is too wide and accordingly void.

The clause containing the restrictive covenant is not very well drawn up and more than one meaning can be assigned to that clause. The word 'practice' or 'practise' in that clause could also have more than one meaning.

'Every document should, of course, be read in the light of the circumstances existing at the time, and evidence may rightly be given of every material fact which will place the Court as near as may be in the situation of the parties to the instrument.' (Per Innes, C.J. and Richter *vs.* Bloemfontein Town Council 1922 A.D. 57 at p. 69).

Placing myself in the position of the parties when this covenant was entered into during 1955, and when no one had immediate retirement in mind, I am of the opinion that the parties had only one object and that was to protect the goodwill of the partnership against the competition of a partner who may in the future retire therefrom. It was obvious to them that practising as a specialist or consultant could do no such harm, nor could full time employment with one of the mentioned authorities cause any harm. I do not for one moment think that when the three authorities were mentioned the parties intended to exclude full time employment with other bodies or concerns, employment with whom could in no way harm the goodwill of the partnership. If any one at that time should have asked: 'But what about full time employment with the Chamber of Mines?', I have no doubt that the answer would have been: 'But of course such full time employment could in no way compete with the practice of the remaining partners.' The balance of probabilities are to my mind in favour of the view that their minds were simply not directed to the other types of full time employment. It was merely an oversight and there was no intention to exclude a retiring partner from other forms of full time employment not interfering with the practice of the partnership. Thus interpreted the covenant is reasonable and valid.

In coming to this conclusion I take into consideration the following factors:

(*a*) This was not like a case of a master bargaining from a position of advantage with an employee and imposing upon him a restriction against future competition (New United Yeast Distributors (Pty.) Ltd. *vs.* Brooks, 1935 W.L.D. 75). This case is akin to a person selling a business, where the purchaser reasonably stipulates against competition by the seller. The purchaser is entitled to receive and enjoy what he has purchased and to this end he is entitled to reasonable protection. (Dunbar Enterprises Ltd. *vs.* Green, 1954 (2) A.E.R. 266 at p. 270). The restriction is also in the interest of the seller; because of it, he gets a satisfactory price.

(*b*) Here the parties have negotiated and agreed being equal in their bargaining positions (Vermeulen *vs.* Smit, 1946 T.P.D. 219). Where this is the case, it is in the public interest that such bargains freely entered into should if possible be declared valid and enforced.

(*c*) Where the covenant admits of more than one interpretation it should if possible be interpreted in a way that makes it valid rather than invalid. Accordingly a narrow rather than a wide construction would be preferred. (Wessels, *Law of Contract,* para. 1920).

(*d*) In this case giving an interpretation in favour of validity would in my opinion be in accordance with the true intention the parties had at the time of entering into the agreement. (Wessels, *Law of Contract,* para. 1899).

(*e*) If at all possible the interpretation should be such as would promote justice rather than injustice. An interpretation in favour of invalidity in this case would in my opinion not promote justice, as between man and man. If it can be done without doing violence to the rules of construction the respondent should not be encouraged in his conduct, which is such as one would not expect from a gentleman engaged in an honourable profession. His conduct is not in accordance with:

'Rechtvaerdigheid is een deugd des willis om te doen dat rechtmatig is. Rechtmatig is dat met het recht over-een-komt' (Grotius 1.1.3–3 also Wessels: *Law of Contract,* paras. 1974–1978).

(*f*) Where full time employment with certain authorities has been specifically mentioned, there is a great temptation to argue that *expressio unius exclusio alterius.* Many authorities have warned that this maximum must be applied cautiously. (R. *vs.* Vlotman, 1912 A.D. 136 at p. 145: also Wessels: para. 1954). In a case like the present, where I think there can be no doubt as to the object the partners had in mind, it does not necessarily follow that when certain authorities were mentioned there was an intention to exclude others. Other possible employers were merely not mentioned, I think, because of an oversight (see Haynes *vs.* Doman, 1899 (2) C.R.D. p. 26) and Wessels, *Law of Contract,* para. 1899).

The application will be granted and the order I make is:

1. The respondent, B. S. H., is restrained from practising or being interested in any medical practice other than in full time employment of the Central, Provincial or Local Authorities, either directly or indirectly in Johannesburg for a period of 5 years as from the 1st day of February, 1959.

2. The respondent must pay the costs of these proceedings.

[We are informed that an appeal has been noted.—*Editor.*]

WHAT'S NEW IN OBSTETRICS AND GYNECOLOGY?

J. P. GREENHILL, M.D.*
Chicago, U.S.A.

Obviously, it is impossible to cover all the subjects of obstetrics and gynecology in the very short time allotted to me. I shall, therefore, discuss only a few subjects, particularly the controversial ones, and I shall begin with obstetrics.

* A lecture delivered during the author's recent visit to South Africa. Prof. J. P. Greenhill is Professor of Gynecology, Cook County Graduate School of Medicine.

TREATMENT OF THREATENED AND HABITUAL ABORTION

To-day there is considerable difference of opinion about the treatment of threatened and habitual abortion. Most obstetricians administer hormones, particularly the estrogens, in an effort to save early pregnancies. The basis for this is the belief that the administration of estrogens induces increased production of pro-

gesterone which is essential for the maintenance of early pregnancy. I do not believe that estrogens are essential and, therefore, do not prescribe them at all. I rarely give any form of hormone therapy to patients with threatened abortion. In most of my patients who bleed in the early months of pregnancy, I have the urine studied for pregnandiol. If there is a marked decrease in the amount of pregnandiol, the patient receives 100 mg. of progesterone every single day. This is very expensive treatment and does not help all patients by any means. If the pregnandiol determinations are normal, I prescribe no endocrine treatment at all. I do not have my patients remain in bed more than 7 days, and if they bleed profusely I empty the uterus. We must remember that in perhaps 50% of all cases of spontaneous abortion the conceptus is abnormal and Nature is attempting to get rid of it.

I should like to emphasize that contrary to our teaching of years ago, I urge that in every patient who bleeds in pregnancy, a speculum be inserted into the vagina to examine the cervix. Occasionally one finds that the bleeding is not due to a threatened abortion, but to polyps, to erosions or even to cancer. Therefore, we must use a speculum. Also, we must remember that in some cases of bleeding, especially in the mild cases, there is a tubal pregnancy, and unless one makes a careful bimanual examination, one may overlook an ectopic pregnancy.

TOXAEMIAS OF PREGNANCY

Another subject which I should like to talk upon briefly is the toxaemias of pregnancy. Because of improved prenatal care in large cities we rarely see cases of eclampsia. We do see cases frequently in areas where the patients do not receive proper prenatal care. On the other hand, the frequency of pre-eclampsia is still very high. As in the past, most of the treatment is empiric but to-day we have some very useful drugs which reduce blood pressure and prevent convulsions. Among these are not only Morphine, Magnesium Sulphate, Sodium Amytal and Paraldehyde, but also Veratrum Viride and hypotensive drugs such as Protoveratrine and Apresoline. In pre-eclampsia where patients are not improving under medication, the uterus should be emptied. If this can be done easily through the vagina by rupturing the membranes, that is the preferred treatment, and in some cases this treatment may be combined with the use of intravenous pituitary extract in small doses. If the cervix is closed and the patient is a primigravida, a caesarean section should be done. However, once a patient develops convulsions she is a very sick woman, and I do not believe that a surgical operation such as a caesarean section should be done.

BLEEDING LATE IN PREGNANCY

Bleeding in the last trimester of pregnancy is usually due to placenta praevia, abruptio placentae or rupture of the marginal sinus. The treatment for placenta praevia, in my opinion, is either rupture of the membranes (with or without the use of Willett forceps) or caesarean section. Women who have partial placenta praevia and have not lost much blood should be treated by rupture of the membranes. Patients with total placenta praevia in whom the bleeding is severe should be delivered by caesarean section regardless of the condition of the baby. The operation is done in the interest of the mother and not the baby. We can avoid the loss of some premature babies by not doing anything but wait in some cases of placenta praevia. In cases where the bleeding is not serious, and the baby is not viable, we can wait. The patient should be put to bed and given no treatment. A speculum should be inserted into the vagina to expose the cervix, but with great gentleness. An internal examination with the fingers should not be made because this often starts profuse bleeding and forces emptying of the uterus with delivery of a non-viable baby.

Almost all cases of premature separation of the placenta must have the uterus emptied. The usual treatment is rupture of the membranes, but in some cases caesarean section must be done. We now know that there is a very serious condition, viz. afibrinogenaemia, or hypofibrinogenaemia, which occurs in some patients who have severe abruptio placentae. Therefore, to-day, in all cases of serious bleeding due to premature separation of the placenta, we perform blood clotting tests every hour to see if there is a diminution in fibrinogen. If there is, we administer fibrinogen. It should be given generally in sufficient doses, viz. 10 g., to replace a possible loss of all the fibrinogen in the body. In addition, patients who have afibrinogenaemia should be treated by repeated blood transfusions with fresh blood. As soon as the blood clotting mechanism is restored, the uterus should be emptied either by rupturing the membranes from below, if this can be done with a good outlook for delivery, or by caesarean section, but one

should not operate upon a patient until the blood clotting mechanism has been restored by fibrinogen and blood transfusions. We must also remember that afibrinogenaemia occurs not only in cases of abruptio placentae but also in some women who have a dead foetus retained a long time, in some cases of amniotic fluid embolism, and in some instances of eclampsia. The third common cause of bleeding is rupture of the marginal sinus. However, there is considerable controversy about this diagnosis because some obstetricians maintain they have never seen a case. It does occur and not infrequently.

ANAESTHESIA

Anaesthesia in the United States is used for the vast majority of women who have babies in hospital, particularly private patients. This is both good and bad because while the drugs relieve pain and the patients are grateful for this, there are deaths directly attributable to the injudicious use of all forms of anaesthesia. Inhalation anaesthesia can produce aspiration pneumonitis with a very high death rate. Spinal anaesthesia is now used very extensively. The present popular form is saddle block, but with all forms of spinal anaesthesia there is some danger. In my opinion the danger is greater in women who are having babies than in non-pregnant women and in men. I prefer to use direct local infiltration. I deliver many babies vaginally and by caesarean section under direct infiltration anaesthesia. A caesarean section is a very easy operation to carry out under direct infiltration anaesthesia, and I make a plea for more extensive use of direct infiltration anaesthesia.

In the United States at the present time, because of the troubles that arise following spinal anaesthesia (not only deaths, but also paralyses) there are many lawsuits where patients sue the physician for complications which they believe to be due to the use of spinal anaesthesia. I urge that one should never give spinal anaesthesia to any patient who objects to its use.

DISTURBANCES OF THE BABY

Now I should like to discuss a few serious disturbances of the baby. When German measles occurs in the first trimester of pregnancy, monsters result in a fairly high percentage of cases. When the first reports came from Australia, almost 100% of the babies were defective. To-day we know that this percentage has decreased considerably, and perhaps not even 15% of babies born of mothers who had German measles in the first 3 months of pregnancy are malformed. The question of whether or not to end a pregnancy because of German measles is a debatable one.

A second very important foetal disturbance is hyaline membranes of the lungs. This occurs particularly in premature babies, and is almost never present in a stillborn baby. In other words, a baby must live for at least an hour or two before the hyaline membranes develop. We do not know the cause and as yet we have no cure. The death rate is appalling.

A third disturbance is retrolental fibroplasia, a blindness of newborn babies, chiefly prematue ones. We believe that excessive oxygen administration to these small babies is the cause. If this is so, and I believe it is, then we must be extremely careful about the amount of oxygen we give to newborn babies, especially the premature ones. This does not mean that we should withhold oxygen from babies who need it, but as a routine procedure we should not immediately place small babies in incubators with high percentages of oxygen. In line with these deaths we know that there are some unexplained deaths of full-term babies at caesarean section. In some cases a caesarean section is done on a woman with a live baby whose heart tones are heard immediately before operation yet who is born dead. Autopsy in most of these cases fails to reveal any cause of death whatsoever. The same thing may happen in patients who have diabetes. As you well know, many babies are extremely large in patients with diabetes. Some of these babies do not survive. For this reason in many hospitals in the United States elective caesarean sections are done, at about the 36th or 37th week of pregnancy, when the baby is large. Many of these babies weigh 7½–8 lb., just like full-term babies, but they should be treated as prematures. A plea has been made to gavage the stomach of all babies born of diabetic mothers and all babies born at caesarean section. Some paediatricians believe that this prevents the death of some babies born by caesarean section and of diabetic mothers.

STERILITY

Now, for gynecology. Let us begin with sterility. Everyone knows that for many years textbooks stated that any man who had less than 60 million sperm per c.c. was sub-fertile or sterile. We now know that this is abso-

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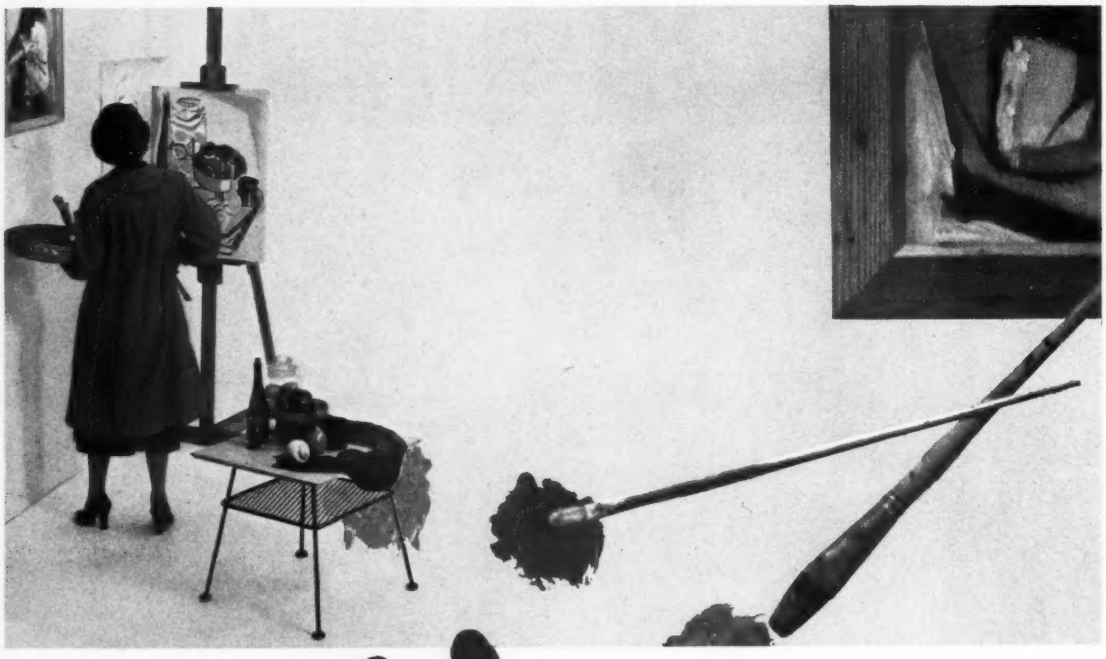

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lutely wrong. There are men who have 30 million, 20 million, 10 million, and even less, who propagate their own children, so that the number of sperm alone is by no means the most important index of fertility. Not only must the sperm count be taken into consideration, but also the volume of semen, the sperm motility, the percentage of abnormal forms and other conditions.

The argument continues as to whether the Rubin gas test is preferable to hysterosalpingography. I believe that both tests are indicated in most women who are sterile. I prefer to do the Rubin test first. If with 2 Rubin tests I find the tubes closed, I then inject an opaque medium and take X-ray pictures. You know, of course, that in some parts of the world, tuberculosis is a fairly common cause of sterility. In the United States this is not so, but in many other countries between 5–10% of the women who complain of sterility have proved endometrial tuberculosis and, of course, in almost all cases where there is tuberculosis of the endometrium, there is also tuberculosis of the tubes. Unfortunately, even with such excellent drugs as Streptomycin, PAS and Isoniazid, which are most helpful in pelvic tuberculosis, very few women become pregnant, and only rarely is a baby born after treatment.

It is important to know whether or not ovulation is present in sterility cases. It is fairly easy to tell whether ovulation occurs by means of temperature charts, endometrial biopsy, vaginal smears, hormone tests, etc. However, we have no absolutely reliable test to indicate exactly when ovulation is occurring in women. We need this very badly. In the last few years we have come to learn that in some instances the character of the cervical mucus is important in the study of sterility.

I wrote a paper on the subject of operations on closed Fallopian tubes 20 years ago, which was very pessimistic, and while the results today are much better than they were then, they are still far short from being satisfactory, in my opinion.

As you know, in patients who do not ovulate, we have considerable trouble in producing ova. Logically, pituitary hormones should be used, but in my opinion these are of very little use in human beings to produce eggs. We do have a procedure, namely X-ray treatment of the pituitary, the ovaries, or both, which does give good results. In about 70–75% of the cases menstruation occurs in patients who never have menstruated, and about 50% of women who do not ovulate have babies following X-ray treatment. However, because of what we know to occur in some animals, I am afraid of what may happen in the third, fourth and fifth generations. In cases of Stein-Leventhal syndrome, parts of the ovaries are resected.

MALE STERILITY

As regards sterility in the male, the outlook is very poor. Men who have no sperm cannot be made to produce sperm. Men who have very few motile sperm likewise cannot be helped much. We have a procedure, of course, viz. artificial insemination, which will enable a woman whose husband has aspermia to have babies. We use a donor in cases where the man has no sperm at all. At the present time there is considerable agitation about artificial insemination where a donor is used. The law courts have a few cases of this type where, after a child is born following artificial insemination, trouble arose and the husband started a lawsuit to prove that the baby was not his. In my State, Illinois, a judge last year declared that artificial insemination, using a donor's semen, was illegal, and therefore a doctor using this procedure could get into trouble. Semen, frozen for several months, is now being used for artificial insemination.

VAGINAL DISCHARGES

The treatment of vaginal discharges offers very little that is new. The two chief causes of vaginal discharge are *Trichomonas vaginalis* and candidiasis. The latter is usually easy to treat, especially by gentian violet. Trichomonas vaginitis, on the other hand, is being treated by a large number of preparations, but there are many recurrences with all the forms of treatment used.

OVARIAN TUMOURS

During the last 25 years we have come to recognize the 4 types of special ovarian tumours, viz. granulosa cell tumours and thecomas, arrhenoblastomas, dysgerminomas and Brenner tumours. The Brenner tumours, of course, are harmless because there are only 9 cases of malignancy in such a tumour reported in the world literature. However, the other types are malignant. Until recently we believed that the frequency of death following these tumours was only about 30%. We now know, as we have waited longer and longer, that recurrences show up 18, 20 and 25 years

after the original tumour was removed. Therefore these malignancies are more deadly than we thought before. In fact, only a few months ago, there was a report of 70 dysgerminomas with a 5-year follow-up collected from the world literature. The mortality was 73%. In view of this high mortality, the preferred treatment of this condition should be total hysterectomy and bilateral salpingo-oophorectomy, followed by a course of deep X-ray treatment, regardless of the encapsulation or nonencapsulation of the tumour.

CANCER OF THE CERVIX

Now, as regards treatment of cancer of the cervix. The fight still continues between radiation treatment and surgery for early cases of carcinoma of the cervix. In a few clinics experienced surgeons are carrying out surgery with excellent results except for ureteral damage, but usually the treatment in my country is by radiation for all types of cancer of the cervix.

The controversy concerning carcinoma *in situ* of the cervix also continues. There is no doubt in my mind that there is such a thing and that it can be detected easily by means of Papanicolaou smears or by cervical biopsy. In my opinion the treatment for carcinoma *in situ* is simple hysterectomy and not radical hysterectomy.

For the advanced cases of carcinoma of the cervix, as you well know, Brunschwig performs a very radical operation called exenteration. I am not convinced that because we can carry out these extensive operations, removing the uterus, tubes, ovaries, bladder, bowel, and implanting the ureters in the bowel, we are justified in doing this operation on many people. There are some women who want this operation, but I do not think there are many. The death rate, as you know, is high, the care is extensive and very expensive and it is a question whether we have the moral right to urge patients to have this type of surgery in order to prolong their lives maybe 6 months or a year.

OVARIAN CARCINOMA

We do not know much about carcinoma of the ovary. We do know that when cancer of the ovary occurs the death rate is extremely high, and we cure very few patients. Of course, if we remove all ovaries at the time of a hysterectomy for benign conditions, we prevent cancer of the ovary in those women. However, if we remove ovaries routinely in women who have a hysterectomy for a benign condition, many women will have sudden change of life symptoms and sudden mental upsets. The question has not been settled as to whether we are justified in routinely taking out normal ovaries at the time of hysterectomy even in women 45 years old and older.

PSEUDOHERMAPHRODITISM

The question of what to do with pseudohermaphrodites is changing considerably. In former years when an individual had male gonads, an attempt was made surgically to make him a man, and *vice versa.* When a person had female gonads, an attempt was made to make a female out of that person. We know to-day that psychologically this is all wrong; that regardless of the gonads, the external characteristics and the manner in which a child is raised are very important in the decision as to what sex the individual should follow. We now have 2 reliable tests to determine the actual genetic sex of a person. Barr and his associates in Canada found that they can tell maleness and femaleness by studying a piece of skin from an individual. Typical cells of a female contain a chromatin mass which is usually located immediately adjacent to the nucleolus. This is not found in males. The proper sex can also be determined by studying oral smears, peripheral blood, neutrophils and other tissues. Hence, we can tell the genetic sex of a hermaphrodite or a pseudohermaphrodite even at birth. Also, Zondek and Finkelstein, in Israel, have devised a urine chemical test for the detection of the genetic sex of a person where it cannot be determined by physical means. These tests avoid the necessity for opening the abdomen to try to find out whether a person has ovaries or testicles. Sometimes, even at laparotomy, this is not possible by just looking at the gonads. By studying the chromatin in the cells obtained from liquor amnii we can correctly predict the sex of a child before birth.

ENDOCRINE THERAPY

Lastly, may I mention briefly, endocrinology. In most instances endocrines are helpful, but in some instances they do harm, and sometimes they do neither good nor evil except for the money spent. There is no doubt that the estrogens are useful in the menopause, but in my opinion not one in five women who is having menopausal symptoms requires estrogen therapy. I rarely ever give hypodermic medication. Nearly all medication for the meno-

pause can be by mouth, because we have excellent preparations to-day. Either estrogens or androgens may be used to control excessive uterine haemorrhage, but in every case of abnormal or excessive bleeding one must be sure to rule out cancer, regardless of the patient's age. Dysmenorrhoea sometimes can be relieved by means of estrogens to suppress ovulation. Androgens also can be used for that purpose. Premenstrual tension is a very common occurrence. By this we mean a group of symptoms occurring 7–10 days before menstruation where women become distended abdominally, have headaches, drop things, find their clothes are tight, and become irritable. The treatment that I like best is simple ammonium chloride, but androgens also help. In amenorrhoea the results are not good. As I said before, pituitary hormones should be given, but they are not satisfactory. Many women can be made to bleed by means of estrogens alone, or estrogens followed by progesterone, or progesterone alone, but this is not true menstruation because no egg is produced. To produce ova, pituitary preparations should be used, but they are not good, and therefore we sometimes resort to X-ray treatment. We must also remember that there are dangers from both estrogens and androgens. Estrogens produce bleeding and pain in the breasts and other disturbance. Androgens often produce signs of virilism.

In closing may I point out that in recent years psychosomatic gynecology has become important. Unfortunately, there are many doctors who use this term because they do not know what is troubling a patient. There is no doubt whatever that in many cases the psyche has much to do with a patient's symptoms. There are many cases of the menopause where the fears the patient has about how she will look and act have something to do with her symptomatology. In some instances of sterility the mind plays an important role by producing tubal spasm, and other conditions. Certainly in some cases of dysmenorrhoea fear and tension have something to do with the pain. Also in amenorrhoea, and especially during the war years, the women who were in concentration camps had amenorrhoea based on disturbances of the hypothalamus and pituitary.

BENIGN EPITHELIAL TUMOUR OF THE SMALL INTESTINE

A REPORT OF THREE CASES

T. COETZEE, M.CH.
Pietermaritzburg

The purpose of this paper is to put on record three cases of benign epithelial neoplasm of the small bowel: two in the terminal ileum (both presenting with recurrent intussusception) and one in the duodenum (an adenoma arising from Brünner's glands and associated with von Recklinghausen's neurofibromatosis).

Case 1. B. C., a Bantu female aged 54 years, was admitted to Edendale Hospital on 26 February 1957. She complained of pain in the right side of the abdomen. It had been present intermittently for 4 months. It radiated from the lower thoracic spine on the right side to the region of the umbilicus. At times it was quite severe and associated with nausea and vomiting. Some diarrhoea usually followed the attacks of pain and she noticed excessive mucus in the stools. There were no urinary symptoms. Menopausal amenorrhoea had started 4 months before.

She was a stout woman, appearing to be in good health, afebrile, with a pulse rate 80 per minute. The lung fields were normal on X-ray and clinical examination, and the blood pressure was 140/90 mm. Hg. The blood picture was normal, haemoglobin 12.2% and the urine and stool normal on microscopy and culture.

The abdomen showed a firm, smooth, ovoid, non-tender mass, of which the lower part was palpable below the tip of the ninth rib on the right side, the upper part disappearing underneath the rib margin. The mass was movable from side to side and appeared to descend late in inspiration. Vaginal and rectal examination did not show any abnormality. Intravenous pyelography showed a normal urinary tract.

Re-examination on the day following admission showed a normal abdomen. The patient had meanwhile lost her symptoms. Three days later she experienced a typical attack of pain and the mass reappeared in the right hypochondrium. A barium enema

at this stage showed the typical appearance of an intussusception (Fig. 1).

A laparotomy was performed on 13 March. An ileocolic intussusception was found with its apex lying at the hepatic flexure. It reduced easily. The terminal 10 inches of the ileum appeared thickened, and irregular masses could be felt through the bowel wall. The remainder of the small bowel and colon was carefully palpated but no abnormality could be found. The abnormal part of the ileum was resected and bowel continuity restored by an ileo-ascending colostomy. The patient tolerated the operation well and convalescence was smooth.

The resected part of the ileum measured 15 inches and showed, on its mucosal surface, multiple polypoid masses. The resection was well proximal to the uppermost tumours. Microscopy showed multiple simple adenomatous polyps of the small intestine (Fig. 2). Adjacent bowel tissue showed no significant pathological change.

Case 2. P. G., an Indian boy aged 5 years, was admitted to the Edendale Hospital on 17 August 1958. The parents said that the child had a sudden onset of severe abdominal pain 15 hours before. Nothing had been passed per rectum since the onset of the pain. The patient had been experiencing attacks of epigastric abdominal pain for 6 months before admission.

He was restless, the tongue very dry and the pulse rate 152 beats per minute. The

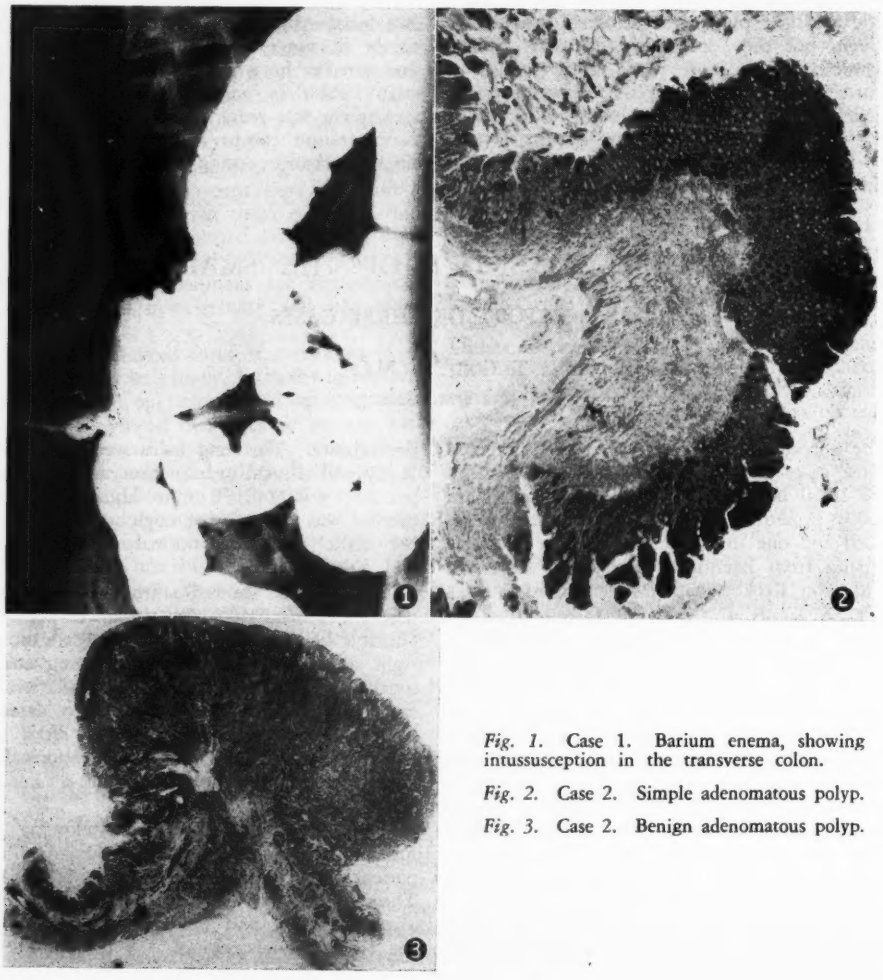
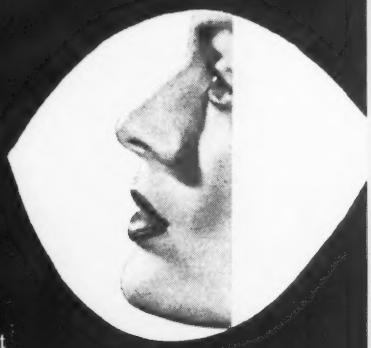


Fig. 1. Case 1. Barium enema, showing intussusception in the transverse colon.

Fig. 2. Case 2. Simple adenomatous polyp.

Fig. 3. Case 2. Benign adenomatous polyp.



Clinical Effectiveness and Versatility
Rapid Relief—in minutes
Enduring Relief—for hours

Excellent results have been reported[1-4] in over 94 per cent of 1058 cases with nasal congestion due to nasal allergies, sinusitis, the common cold, and a variety of other causes. Most patients—including adults and children of all ages—responded immediately to the first instillation of TYZINE, and decongestive action was noted as lasting four to six hours or longer after a single administration.

what the nose needs

Freedom from Rebound Reaction
No Development of Refractoriness
Protection Against Respiratory Complications

Among the more than 2400 cases recorded in preliminary and published studies, rebound engorgement was virtually absent. Typical of all reports: "The appearance of refractoriness after frequent and prolonged use was not observed."[1] Further, TYZINE maintains or rapidly restores normal physiologic functions of the nose, including ciliary motion and an acid pH hostile to secondary bacterial invasion. Indeed, "In addition to symptomatic relief, it was determined that the use of the decongestant shortened the usual course of each disease, and, additionally, either prevented or aborted complications."[2]

Tyzine*

brand of tetrahydrozoline hydrochloride

"a new and superior topical vasoconstrictor"

Pfizer

*Trademark of Chas. Pfizer & Co., Inc.

chest was normal on clinical examination. There was generalized abdominal distension, with loops of distended bowel visible. The hernial sites were normal. There was generalized tenderness, and bowel sounds were absent. The rectum was found empty and there was no blood. The haemoglobin level was 13.1%.

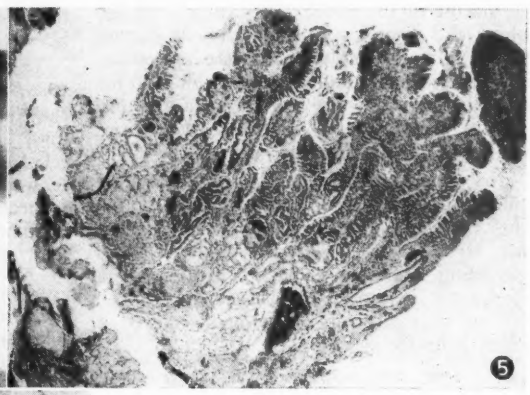
At laparotomy an ileo-ileal intussusception was found. This was reduced with some difficulty. The bowel was viable and an intraluminal mass was felt in the part of the ileum which had formed the apex of the intussusceptum. The bowel containing the mass was resected and a side-to-side anastomosis performed.

The patient developed generalized epileptiform convulsions the next day and died 24 hours after operation.

The resected bowel showed a single sessile tumour on the mucosal aspect. On section it was found to be a benign adenomatous polyp (Fig. 3).

Case 3. M. D., a Bantu male aged 54, was admitted to the Edendale Hospital on 21 August 1956, with a provisional diagnosis of carcinoma of the stomach. During the previous 2 months he had vomited almost everything taken by mouth. He had lost his appetite and had lost weight. He had been troubled with constipation and pain on defaecation. There had not been any melaena. He has had numerous small tumours all over the body for many years.

He was grossly wasted and showed the skin changes of vitamin deficiency. He was severely dehydrated. The whole of the trunk was covered with typical neurofibromata. Examination of the cardiovascular and respiratory systems did not show any abnormalities except a blood pressure of 80/60 mm. Hg. The tendon jerks were diminished in both legs. The abdomen showed slight distention of the epigastrium, where splashing could be elicited. Rectal examination revealed an empty capacious rectum, normal on proctoscopy and sigmoidoscopy. The blood showed a haemoglobin level of 12.9%; blood urea, 59 mg. per 100 c.c., and the serum sodium and chloride readings somewhat below normal. Barium studies revealed a filling defect (arrow) in the upper portion of the second part of the duodenum (Fig. 4). Initially there was delay in the emptying of the stomach, but



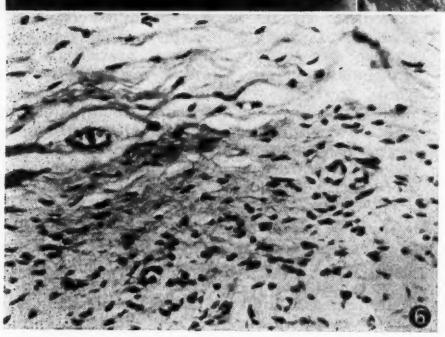


Fig. 4. Case 3. The appearance on a barium meal showing the filling defect in the duodenum. This is indicated by the arrow in the tracing.

Fig. 5. Case 3. Histological appearance of the duodenal tumour.

Fig. 6. Case 3. Histological appearance of a cutaneous neurofibroma.

considerable emptying had occurred after 2 hours. There was no evidence of stenosis at the pylorus.

After dehydration had been corrected and a blood transfusion given, a laparotomy was performed on 6 September. A dilated stomach was found. A tumour could be palpated in the second part of the duodenum, about 4 cm. in diameter, but its nature remained uncertain. The patient reacted very poorly to the anaesthetic and permitted only the performance of a posterior gastro-enterostomy.

The post-operative course was smooth and the patient was soon able to take a full nutritive diet and gained weight rapidly. A further operation was undertaken on 5 October. The mass in the duodenum was thought to be so closely related to the common bile duct that it was exposed by a trans-duodenal approach. The bile duct was opened above the duodenum and a catheter passed along it into the duodenum to act as a marker during the operation. A well-circumscribed tumour, about 3 cm. in diameter, covered with normal looking mucosa, was found attached to the duodenal wall on its medial aspect above the papilla of the bile duct. The tumour had all the appearances of benignity. It was excised, the mucosa of the duodenum sutured over the defect and the incision in the duodenum closed. After completion of the operation, one of the neurofibromata was removed for histological study. The patient made an uneventful recovery and was discharged from hospital on 23 October.

Histological preparations of the duodenal tumour showed a well-defined tumour in the submucosa and muscular layers with a compact structure of well-differentiated glands resembling Brünner's glands. There were no histological indications of malignancy (Fig. 5). Sections of the cutaneous tumour showed a typical neurofibroma (Fig. 6).

DISCUSSION

Neoplasms of the small intestine are uncommon. Of the reported cases the majority are non-epithelial in type. Pearce[4] collected reports of 320 cases of which 58 were adenomata.

The adenomatous group can be subdivided into those in which the tumours are multiple (polyposis of the small intestine), sometimes with polyps in the large intestine and stomach as well, and those in which only a solitary tumour is present. The single type is 4 times more frequent than the multiple.[1] In the first group, there is often an associated pigmentation (most frequently of the face and mouth) and a strong family history,[5] these features constituting the Peutz-Jegher's syndrome.[2] A family history is frequently not obtained.[3, 6]

These adenomatous tumours are most often found in the ileum (about 50% of cases), less frequently in the duodenum and jejunum. They usually present with obstruction (small bowel obstruction in an adult with no previous history of intra-abdominal operation is suspicious), symptoms suggesting intussusception or melaena, which may lead to marked anaemia.[6] The suspicion will be strengthened if, in addition to these features, no radiological abnormalities are found in the oesophagus, stomach or colon.[4]

In the 3 cases here reported, all were epithelial tumours, one a solitary intra-luminal adenoma causing obstruction of the duodenum, another presenting as a localized polyposis of the lower ileum with recurrent episodes of intussusception and small bowel obstruction, and the third, a solitary polyp of the lower ileum, presenting in the same way. There were no pigmentary changes or suggestive family history in any of these cases. The patient with the duodenal tumour also had cutaneous neurofibromatosis.

Treatment by resection of a short loop of lower ileum in Case 1, and local resection of the tumour after preliminary gastro-enterostomy in Case 3, gave complete symptomatic relief. Case 2 did not survive the operation. It would probably have been wiser to have reduced the intussusception only at the initial operation, and to have followed later with a local removal of the tumour.[1]

OPSOMMING

Adenomatose gewasse van die ingewande word veral dikwels in die kronkelderm aangetref (ongeveer 50% van alle gevalle), en minder dikwels in die twaalfvingerderm en die nugtere derm. Verstopping is gewoonlik aanwesig (dundermverstopping by 'n volwassene met geen voorafgaande geskiedenis van 'n binnebuikse operasie nie moet met agterdog bejeën word), sowel as simptome wat derminstulping of swart outlasting suggereer en aanleiding tot opvallende bloedarmoede kan gee.[6] Die agterdog word gesterk as, benewens hierdie kenmerke, geen radiologiese abnormaliteite in die slukderm, die maag of die dikderm aangetref word nie.

Die drie gevalle waaroor verslag gedoen word, was al drie gevalle van epiteelgewasse. Die een was 'n binne-buisholte-adenoma wat die twaalfvingerderm verstop het. Die tweede het hom voorgedoen as 'n gelokaliseerde polipose van die onderste gedeelte van die kronkelderm met wederkerende episodes van derminstulping en dunderm-obstruksie.

Die derde was 'n enkele poliep van die onderste gedeelte van kronkelderm wat homself op 'n dergelike wyse vertoon het. Daar was geen pigmentveranderings of suggestiewe familiegeskiedenis in een van die drie gevalle nie. Die pasiënt met die gewas in die twaalfvingerderm het ook aan huidneurofibromatose gely. Die behandeling—uitsnyding van 'n kort lus van die onderste gedeelte van die kronkelderm in die eerste geval, en plaaslike uitsnyding van die gewas na voorafgaande gastro-enterostomie in Geval No. 2—het volledige simptomatiese verligting aan die pasiënte besorg. Pasiënt No. 2 het die operasie nie oorleef nie. Dit sou waarskynlik verstandiger gewees het om slegs die derminstulping tydens die aanvanklike operasie te verminder, en om dan later oor te gegaan het tot die plaaslike verwydering van die gewas.[1]

This paper is submitted for publication by the kind permission of the Director of Medical Services, Natal.

REFERENCES

1. Aird, I. (1957): *A Companion in Surgical Studies,* 2nd Ed. Edinburgh & London: E. & S. Livingstone Ltd.
2. Jeghers, H., McKusick, V. A. and Katz, K. H. (1949): New Eng. J. Med., **241,** 993, 1031.
3. Kitchin, A. P. (1953): Brit. Med. J., **1,** 658.
4. Pearce, A. E., Luker, M. and Oller, S. (1954): Surgery, **36,** 299.
5. Pool, R. M. and Guice, C. E. (1955): Ann. Surg., **141,** 664.
6. Van Wyk, F. A. K. and Glen, A. M. (1956): S. Afr. Med. J., **30,** 609.

THE ELIMINATION OF CHILDREN'S PHOBIAS

BY DECONDITIONING

ARNOLD A. LAZARUS, M.A. (RAND)
Johannesburg

The therapeutic properties of direct deconditioning were first demonstrated by Jones[1] in 1924. Jones eliminated fear-reactions in young children by coupling the feared objects with pleasant stimuli. She wrote:

'The hunger motive appears to be the most effective for use in this connection. During a period of craving for food, the child is placed in a high chair and given something to eat. The fear-object is brought in, starting a negative response. It is then moved away gradually until it is at a sufficient distance not to interfere with the child's eating. . . . While the child is eating, the object is slowly brought nearer to the table, then placed upon the table, and finally as the tolerance increases it is brought close enough to be touched.'

Until recently, the comprehensive psychotherapeutic value of deconditioning procedures remained relatively unexplored. Sears and Cohen,[2] Guthrie,[3] Max,[4] Mowrer and Mowrer,[5] and Voegtlin[6] were among the first to provide evidence of therapeutic potentials based on this pattern. Most psychotherapists, however, have remained impervious to these and other investigations of the efficacy of techniques which stem directly from the conditioned response. The majority of clinicians appear to view conditioning techniques with suspicion and disfavour and maintain that 'symptom removal' exposes the patient to the dangers of alternative symptoms, greater degrees of anxiety and numerous other undesirable manifestations of the unresolved 'underlying complex.' Many writers, however, notably Eysenck[7—9] and Wolpe,[10—13] have cited widespread clinical evidence which runs counter to this general viewpoint.

Eysenck's[8] lucid distinction between these opposing theories is phrased as follows:

'According to Freud, there is a "disease" which produces symptoms; cure the disease and the symptoms will vanish. According to the alternative view, there is no "disease," there are merely wrong habits which have been learned and must be unlearned. If such "unlearning" and "relearning" is efficacious, and there is no evidence of any "disease," then surely we must dismiss this additional concept as superfluous.'

Follow-up studies[16—19] on cases treated by a variety of methods which did not concern themselves with the uncovering of repressed material have uniformly revealed little or no tendency to relapse. These studies are directly contrary to the psychoanalytic assumption that neurotic disorders can only be resolved by delving into 'unconscious, infantile, repressed material.' The significance of these findings has been summed up by Wolpe[13] as follows:

'If repression were the essence of neurosis, apparently successful measures that leave "the repressed" untouched would be followed before long by relapse, i.e. the emergence of new symptoms or the recurrence of old ones. If, on the other hand, neurotic symptoms are nothing but conditioned responses, "deconditioning" measures . . . will be all that is needed to eliminate the symptoms permanently; and after thorough extinction of the neurotic responses relapse will not be expected.'

Employing methods of treatment based on the hypothesis that neurotic responses can be eliminated by deconditioning, Wolpe has reported a 90% level of apparent cures or marked improvements in over 200 cases. Follow-up studies on 45 patients, 2 to 7 years after the end of treatment, revealed that only

one patient had suffered a moderate relapse after about a year.

Independent corroboration of Wolpe's findings on adult patients have been presented elsewhere.[14, 22] The present paper is concerned with the application of Wolpe's methods to the field of child therapy. We have already discussed how Jones employed feeding responses in overcoming neurotic anxieties in children. Wolpe has shown that there are numerous responses (apart from feeding) that are capable of inhibiting anxiety. In the main, our own child therapy programmes have made use of feeding responses, relaxation responses, conditioned avoidance responses and drugs in deconditioning. We shall illustrate these techniques by reference to actual case histories. The examples which follow have been selected from our case records of 18 phobic children who were treated by these specific deconditioning techniques.

ILLUSTRATIVE CASE RECORDS

DECONDITIONING BASED ON FEEDING RESPONSES

John D., 8 years old, developed a fear of moving vehicles 2 years after he and his parents had been involved in a motor car accident. He refused to enter any vehicle and on one occasion when his father had unwisely forced him into his car, the child became panic-stricken and hysterical.

Therapy consisted of first talking to John about trains, aeroplanes, buses, etc. Even this 'mild exposure to the stimulus' tended to evoke anxiety in the child, but whenever he volunteered a 'positive' comment, he was casually offered his favourite chocolate. During the third interview, John willingly spoke at length about all types of moving vehicles and there was no longer any evidence of overt anxiety.

A series of deliberate 'accidents' with toy motor cars constituted the next phase of the treatment project. The child evidenced a fairly high level of initial anxiety. After each 'accident' he was given chocolate. His anxiety was soon dissipated and he entered into the full spirit of the game.

The next step in the therapy programme consisted of sitting with the child in a stationary motor car while discussing the accident in which he had been involved. He was provided with liberal helpings of chocolate throughout this discussion. Thereafter the child was taken in a car for short distances. At the 17th session (less than 6 weeks after therapy had commenced) he willingly entered a car and, accompanied by a complete stranger, he set off for a shop 1½ miles away where he bought chocolate. At first, he refused to go motoring with his parents unless he was given chocolate, but he soon began to enjoy motoring for pleasure.

SYSTEMATIC DESENSITIZATION BASED ON RELAXATION

Carol M., 9½ years old, had been an apparently healthy and well-adjusted child until about 2 months after her ninth birthday, when she became enuretic, afraid of the dark and displayed a variety of symptoms ranging from night terrors to what her doctor had labelled 'psychosomatic ailments.' While at school she invariably developed violent abdominal pains so that her teacher had to excuse her from class and would eventually have to send for her mother.

Immediately before the onset of her anxieties, Carol had been exposed to 3 successive traumatic incidents in the span of a few weeks. A school friend had fallen into a pond and drowned; her next-door playmate contracted meningitis and died; she had witnessed a motor car accident in which a man was killed.

During an interview with Carol's mother, Mrs. M. stated that she had read an article which stressed that one should refrain from giving a 9-year-old child any overt demonstrations of love and affection (such as hugging or kissing the child) since these practices supposedly hindered the development of 'personality and maturity.' The therapist vehemently condemned this contention and provided 'handling instructions' which emphasized the necessity for deliberate and overt love and warmth.

A month later Mrs. M. telephoned the therapist and reported that the family had been away on vacation for over 3 weeks, during which time Carol's behaviour had been 'perfectly normal.' Since their return, however, Carol bedwetted each night and had become hysterical when taken to school. 'She's worse than ever,' Mrs. M. declared. 'The child won't let me out of her sight.'

When Carol returned for therapy she insisted that her mother should be present during the interviews. Her condition had deteriorated

considerably. She was extremely agitated and tense and anxiously clung to her mother.

During the diagnostic interviews, it became apparent that the child's central fear was the possibility of losing her mother through death. Projective testing also suggested that she was in fact not afraid to go to school, but she was afraid that her mother might die before she returned home from school. Similarly, she was not afraid to sleep alone, but she feared that her mother might die before the night was over. Whereas psychoanalysts might have interpreted this in terms of a 'death wish,' we found it unnecessary to account for the child's behaviour in terms of inferred constructs and simply regarded the child's neurotic reactions as having been precipitated by her sudden and harsh exposure to the traumatic realities of death. Since Carol's premature awareness of the finality of death had coincided with her mother's misinformed attitude to displays of love and affection, the child's consequent feelings of rejection finally culminated in a genuine fear of permanent maternal deprivation (i.e. death). Thus, even a brief period of separation from her mother aggravated Carol's anxieties. Our therapeutic approach involved a planned and deliberate attack on this anxiety by systematic desensitization (see below).

Wolpe's method of systematic desensitization based on relaxation makes use of Jacobson's finding[23] that muscular relaxation inhibits anxiety and that their concurrent expression is physiologically impossible. Details of the theoretical rationale and clinical application of this technique are presented elsewhere.[12, 13, 22] Briefly, the patient is given progressive training in relaxation in the course of several interviews and during the same interviews an 'anxiety hierarchy' is constructed, i.e. a graded list of stimuli to which the patient reacts with unadaptive anxiety. The following anxiety hierarchy was constructed for Carol M.

Separation from the mother for 1 week.
Separation from the mother for 2 days.
Separation from the mother for 1 day.
Separation from the mother for half a day.
Separation from the mother for 1 hour.
Separation from the mother for 15 minutes.
Separation from the mother for 5 minutes.

The patient, while fully relaxed, is asked to imagine the individual items of the anxiety hierarchy, starting with the least noxious situation ('Imagine that you are not going to see your mother for 5 minutes') until eventually, the most 'difficult' item is presented ('Imagine that your mother is leaving you for one whole week'). Repeated reciprocal inhibition in this manner eventually leads to the development of conditioned inhibition.[13, 24]

It took 5 sessions spaced over 10 consecutive days to desensitize Carol completely to the subjective threat of maternal deprivation. Therapy had commenced on a Tuesday. On the following Friday Carol willingly went to school. This was followed by an immediate dissipation of all her other neurotic conditions. A 15-month follow-up enquiry revealed that apart from very occasional enuretic incidents, she had maintained an eminently satisfactory level of adjustment.

THE USE OF DRUGS IN DECONDITIONING

Douglas G., 3½ years old, had displayed severe phobic reactions to dogs ever since one had bitten him nearly 5 months before. His parents subsequently had obtained a puppy in the hopes that this would enable him to overcome his fears. Unfortunately the child only became hysterical whenever he saw the animal, so that his parents were forced to dispose of it. Douglas soon displayed similar phobic reactions to cats and birds, so that eventually he became afraid to venture out of doors. The child was excessively active and distracted, but a detailed medical and neurological examination revealed no organic pathology. His activity level precluded the application of relaxation techniques. Consequently, he was given small doses of amobarbital and phenaglycodol (under medical supervision) for 3 days until a satisfactory level of sedation had been achieved. He was then gradually introduced to a variety of animals without displaying any anxiety. Administration of these drugs was gradually reduced over a period of 5 weeks. A follow-up was conducted almost a year later and revealed that the child had not relapsed in any respect.

DECONDITIONING OBTAINED BY CONDITIONED AVOIDANCE RESPONSES

Ever since he had learned to walk, Brian E., 10 years old, had made a habit of waking up and going to his mother's bed in the very early hours of the morning. An assortment of punishments, threats, bribes and rewards had each failed to modify his behaviour. The child 'automatically' awoke between 1 a.m. and 2 a.m. and would immediately go to his mother's bed. On one occasion, Mrs. E. had decided

that if she adamantly refused to have him in her bed he might eventually sleep in his own bed. The result was that Brian spent nearly 4 hours crying outside her bedroom door and she was finally forced to allow the child into her bed.

Professional advice was sought when Mrs. E. broke her ankle and found it acutely uncomfortable to share her bed. Furthermore, at this stage Brian's behaviour was seriously disrupting personal relationships in the home. When questioned about his behaviour, Brian indicated that he very much wanted to sleep in his own bed but that when he awoke, anxiety would mount within him and he would become panic-stricken unless he went to his mother's bed. Although the security of his mother's bed constituted a potent source of anxiety-relief, we endeavoured to remedy the situation by means of simple avoidance conditioning.

Max[4] was the first to show that an unpleasant electric shock in the presence of an obsessional object tends to produce a persistent avoidance reaction to the object. Conversely, it has been shown that approach responses are conditioned to a stimulus repeatedly presented at the moment of termination of an electric shock.[25-28] Consequently, the following technique was employed:

Zinc electrodes, attached to the child's left forearm, were connected to the secondary circuit of an induction coil whose primary was wired to a 6-volt dry battery. The patient was asked to imagine* himself in his mother's bed and to say the words 'mother's bed' as soon as he had a clear image of the situation. A mild electric shock (at an inductorium setting of 9 cm.) was then passed into his forearm. When he could no longer tolerate the shock (average duration of shock, 3.2 seconds) he was instructed to say 'my bed,' at which point the current was immediately switched off. This procedure was repeated 14 times over a period of about 10 minutes.

Brian was seen again a week later and he announced with great pride that he had slept in his own bed every night. He stated that although he had awakened as usual for the first 5 nights, he had merely 'turned over and gone back to sleep.' He had slept right through the sixth night, however. At the time of writing, he has slept in his own bed for over 6 months.

This case affords a clear illustration of the fact that 'symptom removal' *per se* is not a static or isolated process but results in a dynamic redistribution of—to use Lewin's term[29]—the relevant 'field forces.' Brian's new-found ability to sleep in his own bed has completely altered numerous adverse environmental pressures. His relationship with his father, e.g. had been most casual and restrained. As soon as Brian had shown that 'he had the makings of a man,' Mr. E.'s attitude towards him underwent a remarkable change. He began displaying an active interest in his son's activities and, whereas previously he had forbidden Brian to keep any pets, he unexpectedly brought home a dog one night. Sibling tensions have also eased considerably. In short, as Mrs. E. expressed it, 'the difference in the home is nothing short of fantastic.'

It might be surprising to some that the removal of a single maladaptive symptom should have had such diverse and important implications. However, this is not difficult to explain. Once the improvement occurred the dynamics of Brian's situation altered markedly in directions which served to consolidate the gain. But there is no doubt that the conditioning procedure provided a strikingly rapid initiation of change. The crucial point, however, is that techniques which reciprocally inhibit neurotic anxieties appear to have widespread and positive repercussions on diverse areas of the individual's personality.

DISCUSSION

We have applied Wolpe's methods of direct deconditioning, based on the principal of reciprocal inhibition,[13] to the field of child psychotherapy. At present, 18 phobic cases ranging in age from 3½ years to 12 years have been treated by these techniques with gratifying results. The cases had all either recovered or were much improved according to Knight's[30] criteria; and follow-up studies conducted over periods of 6 months to 2½ years revealed that none of the children had relapsed in any respect. Compared with other forms of psychotherapy, the duration of treatment has been exceedingly short (mean number of sessions, 9.4).

A number of non-behaviouristic therapists have tended to explain away these (to our mind) promising results in terms of 'transference cures,' 'strengthening of the ego,' and so forth. The methods have also been criticized on the ground that they are 'mechanistic' and 'symptom-centered,' but it must be emphasized that it is a matter of routine to make a thorough preliminary study of the in-

*Wolpe[13] has shown that it is not necessary to present the actual objects or situations.

terpersonal dynamics of the patient as a functioning member of society. It has been suggested that our successes may simply be explained in terms of our subjective confidence in the methods employed and that the methods themselves are suspect. (Does this imply that other psychotherapists have little confidence in their own methods?) It is obvious that the therapeutic atmosphere of empathy and acceptance must in itself reciprocally inhibit neurotic anxieties. Since the deliberate deconditioning techniques were applied within the context of therapeutic warmth, the final explanation of our therapeutic successes must necessarily incorporate elements of

(*a*) Non-specific reciprocal inhibition via the relationship between patient and therapist (common to all types of psychotherapy); and

(*b*) The deliberate and specific reciprocal inhibition of neurotic anxieties as outlined above.

Wolpe's method of systematic desensitization based on relaxation[13, 22] has proved especially valuable in our treatment of childhood phobias. In some cases, modifications of this approach were necessary. For instance, we have found that very disturbed children and cases with poor 'visual imagery' respond more readily to graded presentations of the actual feared objects after the child has been given post-hypnotic suggestions of calmness and relaxation.

In this connexion we may also mention that we have conducted preliminary experiments utilizing pleasurable responses to music in order to inhibit neurotic anxieties reciprocally. The child's favourite music would be played while presenting him with the relevant anxiety-generating stimuli. It is still premature to report on the efficacy of this technique.

SUMMARY

We have applied Wolpe's psychotherapeutic methods based on the principle of reciprocal inhibition to a preliminary group of 18 phobic children.

Our gratifying results indicate that these methods are eminently effective in the management of childhood phobias.

Follow-up enquiries after 6 months to 2½ years have shown no evidence of relapse in any form.

OPSOMMING

Ons het Wolpe se psigoterapeutiese metodes, gegrond op die beginsel van wederkerige inhibisie, op 'n voorlopige groep van 18 angsbevange kinders toegepas.

Ons verblydende resultate dui daarop dat hierdie metodes hoogs doeltreffend vir die behandeling van kindervrees is.

Navolgingswerk wat 6 maande tot 2½ jaar ná die behandeling gedoen is, het geen bewys van heraanvalle in enige vorm opgelewer nie.

REFERENCES

1. Jones, M. C. (1924): J. Exp. Psychol., **7,** 382.
2. Sears, R. R. and Cohen, L. H. (1933): Arch. Neurol. Psychiat., **29,** 260.
3. Guthrie, E. R. (1935): *The Psychology of Learning.* New York: Harper.
4. Max, L. W. (1935): Psychol. Bull., **32,** 734.
5. Mowrer, O. H. and Mowrer, W. M. (1938): Amer. J. Orthopsychiat., **8,** 436.
6. Voegtlin, W. L. (1940): Amer. J. Med. Sci., **199,** 802.
7. Eysenck, H. J. (1953): *Uses and Abuses of Psychology.* London: Pelican.
8. Eysenck, H. J. (1957): *The Dynamics of Anxiety and Hysteria.* London: Routledge and Kegan Paul.
9. Eysenck, H. J. (1957): Med. World, **86,** 333.
10. Wolpe, J. (1950): S. Afr. Med. J., **24,** 613.
11. Wolpe, J. (1952): S. Afr. Med. J., **26,** 825.
12. Wolpe, J. (1954): Arch Neurol. Psychiat., **72,** 205.
13. Wolpe, J. (1958): *Psychotherapy by Reciprocal Inhibition.* Stanford University Press and Witwatersrand University Press.
14. Lazarus, A. A. (1958): S. Afr. Med. J., **32,** 660.
15. Meehl, P. E. (1956): In a Foreword to Phillips, E. L. *Psychotherapy: A Modern Theory and Practice.* London: Staples Press Ltd.
16. Luff, M. C. and Garrod, M. (1935): Brit. Med. J., **2,** 54.
17. Hamilton, D. M. and Wall, S. H. (1941): Amer. J. Psychiat., **98,** 551.
18. Salter, A. (1952): *Conditioned Reflex Therapy.* London: George Allen and Unwin Ltd.
19. Phillips, E. L. (1956): *Psychotherapy: A Modern Theory and Practice.* London: Staples Press Ltd.
20. Wolpe, J. (1948): *An Approach to the Problem of Neurosis Based on the Conditioned Response.* M.D. Thesis, Witwatersrand University.
21. Wolpe, J. (1952): Bri. J. Psychol., Gen. Sect., **43,** 243.
22. Lazarus, A. A. and Rachman, S. (1957): S. Afr. Med. J., **31,** 934.
23. Jacobson, E. (1938): *Progressive Relaxation.* Chicago: University of Chicago Press.
24. Wolpe, J. (1952): Psychol. Rev., **59,** 192.
25. Barlow, J. A. (1955): Psychol. Rev., **63,** 406.
26. Coppock, H. W. (1951): Amer. Psychologist, **6,** 277.
27. Goodson, F. A. and Brownstein, A. (1953): J. Comp. Physiol. Psychol., **48,** 381.
28. Smith, M. P. and Buchanan, G. (1954): J. Exper. Psychol., **48,** 123.
29. Lewin, K. (1931): *In* Murchinson, C. (ed.) *A Handbook of Child Psychology,* pp. 590–625. Worcester, Massachusetts: Clark University Press.
30. Knight, R. P. (1941): Amer. J. Psychiat., **98,** 434.

NOTES AND NEWS : BERIGTE

Mr. Wilfred Kark, F.R.C.S., has returned to Johannesburg from a visit to overseas clinics and has resumed practice.

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Drs. Roberts, Kramer, Caswell and van Hasselt (Anaesthetists) have opened additional rooms at 3, Admirals Court, Rosebank, Johannesburg. (*Telephones*: 22-8614; 22-6553; 22-8677).

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Dr. C. F. Krige, M.A., M.B., F.R.C.S., F.R.C.O.G. and Dr. P. Boorsma, M.B., Ch.B. (Cape), M.D. (Groningen), are practising in partnership as specialists in gynaecology and obstetrics at 103 Lister Building, Jeppe Street, Johannesburg. (*Telephones*: *Rooms*: 22-4819; *Residences*: Dr. Krige: 42-1836; Dr. Boorsma: 46-1543).

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Dr. Carl Barrett, M.B., Ch.B. (Leeds), M.R.C.O.G., D.Obst.R.C.O.G., who recently returned from a prolonged post-graduate visit overseas (where he spent 5 years at the Hospital for Women at Leeds and the Maternity Hospital at Leeds) has commenced practice as a Specialist Obstetrician and Gynaecologist at 26–27 Jenner Chambers, Jeppe Street, Johannesburg. (*Telephones*:—*Rooms*: 22-4464; *Residence*: 46-4968).

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WELLCOME FILM LIBRARY

Burroughs Wellcome & Co. (South Africa) Limited, have available on loan, free of charge, 3 new films which have been added to their Wellcome Film Library. The 16 mm. films (which are in sound and colour) are:

1. *Ergot: The Story of a Parasitic Fungus* (running time: 7 minutes).
2. *The Routine Use of Ergometrine in the Third Stage of Labour* (running time: 7 minutes).
3. *The Management of Twins in Pregnancy and Labour* (running time: 22 minutes).

Those interested in borrowing these films should communicate with: The Wellcome Film Library, P.O. Box 10293, Johannesburg.

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SOUTH AFRICAN MEDICAL COUNCIL

Communications addressed by the Registrar to the practitioners mentioned below have been returned undelivered. The persons concerned are advised to communicate with the Registrar without delay advising him of their correct address for entry in the register:

Sirkulêres wat deur die Registrateur aan die ondervermelde geneeshere gerig is, is onafgelewerd teruggestuur. Die betrokke persone word aangeraai om sonder versuim met die Registrateur in verbinding te tree en hom van hul korrekte adresse vir inskrywing in die register in kennis te stel:

Name *Naam*	*Present Registered Address* *Huidige Geregistreerde Adres*
J. Carnegie	P.O. Kei Mouth, via East London.
M. B. Hodes	1 Winchester Road, Mowbray, C.P.
P. G. M. G. Jones	c/o Dr. A. Wailer, N.B.S. Building, 20 Main Street, Port Elizabeth.
W. J. Kruger	Hospitaal, Middelburg, Tvl.
L. Lambinon	36 Navigation Road, Iscor Township, Pretoria.
D. R. Lee	c/o Barclays Bank, D.C.O., Oceanic House, 1 Cockspur Street, London, S.W.1, England.
M. F. Mathews	c/o 11 Howard Centre, Pinelands, Cape Town.
R. J. S. Metz	11 Tyrone Avenue, Parkview, Johannesburg.
D. J. C. Roberts	53 Medical Centre, Field Street, Durban.
G. E. J. Seymore	Algemene Hospitaal, Pretoria.

PREPARATIONS AND APPLIANCES

TYROMIST

A UNIQUE TREATMENT FOR SORE THROATS

Westdene Products (Pty.) Ltd. announce the availability of *Tyromist*, manufactured by British Schering of London.

Tyromist is an antibiotic, analgesic spray for the treatment of sore throat. Presented in a plastic atomizer, *Tyromist* provides a pleasant, safe and

more effective form of treatment because the unique spray ensures that the fine mist covers the whole of the inflamed area, including the posterior wall of the pharynx and the tonsillar region. Consequently *Tyromist* relieves the soreness of the inflamed throat within seconds of application and its powerful antibacterial action ensures that any infection caused by susceptible organisms is quickly eliminated.

Tyromist is principally indicated for the immediate relief and effective treatment of the common sore throat, laryngitis and allied conditions. It is also of value as a prophylactic measure following tonsillectomy and other surgical procedures of the mouth and throat and is a useful adjunt to systemic chemotherapy in the treatment of pyrexia or true purulent tonsillitis.

Tyromist is presented in a special plastic atomizer containing 25 ml. (1 fl. oz. approximately) of solution with the following formula:—

Tyrothricin	0.02%
Getrimide	0.05%
Amethocaine Hydrochloride in a demulcent aqueous vehicle	0.05%

Samples and further information may be obtained from the sole South African distributors:

Westdene Products (Pty.) Ltd., P.O. Box 7710, Johannesburg and Branches.

GELUSIL LIQUID

WARNER PHARMACEUTICALS

Description: *Gelusil* Liquid is a new addition to the *Gelusil* range. It combines the advantages of two non-systemic antacids, non-reactive aluminium hydroxide gel and magnesium trisilicate.

Composition: The composition of *Gelusil* Liquid is magnesium trisilicate 0.49 g. (7.50 gr.), aluminium hydroxide 0.26 g. (4.00 gr.) and calcium phosphate (traces).

Action: It reduces gastric acidity without causing acid rebound. Since *Gelusil* Liquid does not neutralize acid, but buffers, the possibility of systemic alkalosis is eliminated. *Gelusil* Liquid is not constipating due to the low order of chemical reactivity of its aluminium hydroxide component. It tends to form a minimum of astringent and constipating aluminium chloride.

Indications: *Gelusil* Liquid is indicated for the treatment of hyperacidity, peptic ulcer and heartburn of pregnancy.

Dosage: 1 or 2 teaspoonfuls as needed.

Presentations: Supplied in bottles of 6 and 12 fluid ounces.

THEOCOL

FOR BRONCHIAL SPASM IN ASTHMA

Zenith Ethical Products introduce their new product *Theocol* for the rapid absorption and sustained high blood levels of theophylline.

Each tablespoonful of *Theocol* contains:

Theophylline	80 mg.
Alcohol	3 c.c.

in a cherry flavoured base.

The oral administration of an alcohol-water solution of theophylline produces a high blood theophylline level in 15 minutes, while a significant concentration persists at least 4 hours after administration.

Indications: Asthmatic attack, asthmatic state, acute bronchitis, chronic asthmatic bronchitis, bronchitis with pulmonary emphysema, congestive bronchitis, pulmonary congestion.

Dosage: Adults: One or two tablespoonsful in water 3 times a day.

Children: According to age.

Presentation: Bottles of 16 fluid ounces.

South African Manufacturers: Zenith Ethical Products, P.O. Box 81, Langlaagte, Transvaal.

MONTUSSIN

AN ANTI-ALLERGIC EXPECTORANT

Montussin is a well formulated antitussive preparation made by Zenith Ethical Products for:

1. The effective treatment of coughs associated with bronchospasm and allergic reactions in the upper and lower respiratory tracts.
2. Relieving the refractory post-influenzal cough and also coughts due to colds.
3. Seasonal catarrhs of the respiratory tract and 'pre-asthmatic' cough.
4. The spasm of whooping cough and croup.

Montussin has combined antihistaminic, broncho-dilating, expectorant and sedative properties and the new improved cherry flavour appeals to children as well as adults.

Each teaspoonful (5 c.c.) contains:

Methapyrilene HCl	10 mg.
Ephedrine HCl	8 mg.
Sodium Citrate	150 mg.
Ammonium Chloride	75 mg.
Tinct. Ipecac. 0.2 m. (3 minims)	

in a specially prepared cherry-flavoured base containing menthol, chloroform and tolu.

Packing: 4 and 16 ounce bottle.

South African Manufacturers: Zenith Ethical Products, P.O. Box 81, Langlaagte, Transvaal.

NEO-MERCAZOLE

FOR THE TREATMENT OF THYROTOXICOSIS

Westdene Products (Pty.) Ltd. announce the availability in South Africa of *Neo-Mercazole* manufactured by British Schering of London.

Since *Neo-Mercazole* was first introduced it has steadily superseded earlier anti-thyroid drugs because of its high therapeutic potency and its greater freedom from toxic side effects. It is now widely accepted as the anti-thyroid drug of choice.

As *Neo-Mercazole* does not make the thyroid gland hard, friable or vascular and consequently difficult to operate on, it is also the ideal drug for rendering patients euthyroid before surgery.

Neo-Mercazole is tasteless and has the added advantage that patients are not required to swallow a large number of tablets each day.

Neo-Mercazole is available as tablets, each containing 5 mg. carbimazole.

Containers of 100 and 500.

Samples and further information may be obtained from the sole South African distributors:

Westdene Products (Pty.) Ltd., P.O. Box 7710, Johannesburg and Branches.

K-GAR DISPOSABLE CLAMPS FOR CATHETERS AND UMBILICAL CORDS

Being introduced to South Africa for the first time are the 'K'-Gar disposable clamps for catheters and umbilical cords.

In addition to their low cost, it has been found that uncomplicated cases may be sent home on their fifth post-partum day and patients are appreciative because no umbilical cord is there to be taken care of when the baby is taken home.

NO. 222 CATHETER

The catheter clamps have also been found to work excellently — a catheter which has been anchored in the patient may be clamped off before going to surgery. They can also be used as clamps on the tubing of intravenous sets.

These clamps are of aluminium with crimping on both sides. The tube to be blocked is placed between the two flaps, which are then pressed together and held in place by the metal tab at one end of the clamp. The whole clamp is then bent slightly to enhance the action of the crimping and maintain an absolute closure of the tube.

The more elaborate clamps have also been successful, but because of the cost and the frequency with which they are lost, they have not been used extensively.

The three distinct values to be derived from the use of this small appliance are:

Ease of application;

Sureness of action;

Relative inexpensiveness and the saving it allows in the re-use of Foley bag catheters.

Stocks of these clamps are available from Gurr Surgical Instruments (Pty.) Ltd., Harley Chambers, Kruis Street (P.O. Box 1562), Johannesburg.

OBLIVON-C

FOR FUNCTIONAL AND PSYCHOSOMATIC DISORDERS

Westdene Products (Pty.) Ltd. announce that *Oblivon-C*, manufactured by British Schering of London, is now available in South Africa.

Oblivon-C is a particularly safe drug which has proved very effective in the treatment of those conditions in which anxiety is the dominant factor. In the day-to-day management of anxiety states, anxiety neuroses, phobic conditions, functional and psychosomatic disorders, *Oblivon-C* effectively relieves the stress factor in these cases by its specific action on anxiety.

Oblivon-C is the most suitable tranquillizer for use in general practice because of its reliable action and its freedom from side effects. There are no contra-indications to its use.

Oblivon-C is available in the form of oval tablets specially shaped to make them particularly easy to swallow. Each ovet contains 100 mg. *Oblivon-C* (Methylpentynol carbamate).

Containers of 25 and 100.

Oblivon elixir (a shorter acting tranquillizer than *Oblivon-C*) rapidly allays fear and reduces tension before minor medical and surgical procedures. It plays an important role in dentistry and pre-anaesthetic medication. It is presented as a palatable liquid which is particularly suitable for children and old people in bottles of 100 ml.

Samples and further information may be obtained from the sole South African distributors:

Westdene Products (Pty.) Ltd., P.O. Box 7710, Johannesburg and Branches.

CORTUCID EYE-DROP CREAM

Westdene Products (Pty.) Ltd. announce that *Cortucid*, manufactured by British Schering of London, is now available in South Africa.

Cortucid is a bland, fluid cream containing the powerful anti-inflammatory agent hydrocortisone

together with sulphacetamide, the bacteriostat of choice for ocular therapy.

Cortucid ensures prompt relief of inflammatory eye conditions whilst protecting the eye against the increased risk of infection associated with the use of hydrocortisone.

Cortucid is of particular value in the treatment of eye conditions in which inflammation is an important factor, whether this be of bacterial, allergic, or of traumatic origin.

Cortucid is presented as a water-miscible, fluid cream which drops readily from the tube and liquefies immediately on contact with the conjunctiva. Since the nozzle does not touch the eye contamination of the contents of the tube is avoided.

Available in 3 g. tubes.

Samples and further information may be obtained from the sole South African distributors:

Westdene Products (Pty.) Ltd., P.O. Box 7710, Johannesburg and Branches.

SECROSTERON

A NEW ORAL PROGESTATIONAL SUBSTANCE

British Drug Houses (South Africa) (Pty.) Ltd., announce the introduction of *Secrosteron*, a new fundamental discovery from the Research Laboratories of the British Drug Houses Ltd., London.

Secrosteron is a new synthetic, orally active, purely progestational substance which has been shown to be approximately 12 times as potent as ethisterone in biological studies. Because of the absence of side effects *Secrosteron* can be given in higher doses than other progestational agents—and preliminary studies indicate that the new substance produces a better and more uniform response in which growth of glandular tissue as well as growth of stromal tissue takes place. *Secrosteron* has no androgenic, oestrogenic or anabolic activity.

Composition: Each *Secrosteron* tablet contains 5 mg. of 6α: 21-dimethyl-ethisterone which has been given the approved name of dimethisterone.

Indications: Habitual and threatened abortion; secondary amenorrhoea; premenstrual tension; menorrhagia; sterility (due to endometrial dysfunction) and metrorrhagia.

Administration and Dosage: *Secrosteron* is given orally. For dosage schedules detailed literature is available on request.

Packings: Bottles of 30 and 100 tablets.

REVIEWS OF BOOKS

PUBLIC HEALTH COURSES

The Foreign Student and Post-Graduate Public Health Courses: Sixth Report of the Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel. World Health Organization: Technical Report Series, 1959, No. 159. 24 pages. 1s. 9d.

Pretoria: Van Schaik's Bookstore (Pty.) Ltd., P.O. Box 724.

Many medical workers who wish to specialize in public health have to seek advanced training in countries other than their own. Certain elements in these post-graduate public health courses, which contribute in meeting the needs of foreign students, and of nationals, are considered by the WHO Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel in its sixth *Report*.

The first requisite is the rapid intellectual and social integration of the student in his class, which requires very careful selection of the candidate, and evaluation of his needs, together with provision for systematic orientation of new students and for counselling. Another element is familiarity of the teachers themselves with the students' home countries, supplemented with information from sponsoring agencies and from ex-students. Once the academic needs of the student have been established, his course of study would be planned to accord with them. To this effect, a very useful device is to have the post-graduate course organized in two sets of subjects, those compulsory for all, plus optional ones responding to the needs of the individual. Tuition should be given as far as possible in small groups: and field training, as well as operational research, are important elements in the instruction. Certain topics should not be overlooked in the subject matter of the public health curriculum, such as planning, budgeting and evaluation in public health administration; elementary environmental sanitation; organization of medical services; principles of teaching and supervision; and instruction in newly emerging aspects of public health. Admission requirements should continue in some degree to take into consideration the different backgrounds of foreign students, who, however, should comply with the level of performance required for obtaining the diploma. The Committee finally emphasizes the need for establishing minimum requirements or general guiding principles applicable to post-graduate training in public health throughout the world.

This *Report* represents the pooling of wide experience accumulated over the period since post-graduate public health courses were first established, and should be of value to the academic and governmental planning authorities concerned with the essential element in the development of public health services: trained personnel.

HYPERTENSION AND CORONARY HEART DISEASE

Hypertension and Coronary Heart Disease: Classification and Criteria for Epidemiological Studies: First Report of the Expert Committee on Cardiovascular Diseases and Hypertension. World Health Organization: Technical Report Series, 1959, No. 168. 28 pages. 1s. 9d.

Pretoria: Van Schaik's Bookstore (Pty.) Ltd., P.O. Box 724.

As mastery is gradually being attained over the major epidemic and endemic infections, the World Health Organization is increasingly turning its attention to the problems of the chronic degenerative diseases. This trend is reflected in the publication

of the First Report of the Expert Committee on Cardiovascular Diseases and Hypertension. This is concerned mainly with the urgent need for properly planned epidemiological studies to establish the true frequency of coronary heart disease, hypertension and related conditions in various countries. It is hoped that such studies will help to clarify the present confused situation and provide important leads for further research and prevention.

After reviewing the public health importance of cardiovascular disease, the *Report* examines the classification of the various forms of hypertension and coronary heart disease and suggests minimal criteria for diagnosis to be used in epidemiological studies. Criticism of these criteria is invited from workers in the field with a view to the future publication of a revised list. An *Annexure* to the *Report* depicts the changes in the electrocardiogram considered to be diagnostic of definite myocardial infarction. It is pointed out that progress in the study of the many factors associated with coronary heart disease and hypertension will depend, not only upon the adoption of uniform diagnostic criteria, but also upon the standardization of clinical, laboratory and field-study methods, and the development of techniques for the assessment of individual diets, psychosocial factors and physical activity. Emphasis is laid on the lack of trained and experienced epidemiologists as a major obstacle to the development of field studies, and the *Report* urges that one of the first tasks be the implementation of a broad training programme on an international basis.

Statistical studies on mortality from cardiovascular disease in different countries are further handicapped by varying practices with regard to death certification and the classification of causes of death by national offices of vital statistics. The *Report* recognizes that the section of the *International Classification of Diseases* relating to the circulatory system is complicated and difficult to apply, but it points out that the application of uniform diagnostic criteria would facilitate the use of the *Classification* and thus increase the precision of the resulting statistics. A substantial improvement cannot be expected for some time, however, and it is suggested that, in the meantime, existing international tabulations of mortality from cardiovascular diseases would gain in usefulness if they were accompanied by comments concerning their quality and the methods of collection and classification prevailing in the different countries.

CHEST CLINIC PRACTICE

Manual of Chest Clinic Practice in Tropical and Sub-Tropical Countries. By A. J. Benatt, M.D. (Pp. 97 + Index. 1959. With 4 Figs. 10s. 6d.). Edinburgh and London: E. & S. Livingstone Ltd.

The author's extensive experience in establishing clinics for the treatment of pulmonary tuberculosis is of great interest to the practitioner in this country. It is often necessary to deal with this problem under conditions of similar difficulty.

The keeping of adequate records is important in order to make possible the long-term follow up studies so essential when dealing with this particular disease.

The methods used for labelling and filing X-rays which are described in this book, could with great usefulness be studied by those embarking on the establishment of a clinic for the treatment of tuberculosis.

The newcomer in this field will find in this monograph the answer to many practical problems with which he will be faced. The management of the tuberculous diabetic and the care of the tuberculous pregnant woman are examples.

The practical aspects of tuberculin testing and BCG vaccination are discussed in detail and amply illustrated. Nurses as well as doctors should find this book a most useful source of information on this important subject.

IONIZING RADIATIONS AND POST-GRADUATE INSTRUCTION

Post-Graduate Training in the Public Health Aspects of Nuclear Energy: Fourth Report of the Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel. World Health Organization: Technical Report Series, 1958, No. 154; 55 pages. 3s. 6d. Pretoria: Van Schaik's Bookstore (Pty.) Ltd., P.O. Box 724.

Up to a few years ago the danger from ionizing radiations was very limited; X-rays were used mainly in radiology, and the problem of protection concerned chiefly the personnel using such equipment. To-day, the situation has changed; the existence of many newly-developed sources of nuclear radiation, the greatly increased utilization of radio-isotopes, and the disposal of radio-active wastes from nuclear fission, are all factors which constitute a risk not only for those who work with radiation sources and radio-active material, but also for the general public.

The dangers are known, and every effort must be made to limit them to the minimum—largely by prevention, since radiation damage to living tissue is in large measure irreversible and in the present stage of medical knowledge treatment is difficult. Workers in public health must therefore have appropriate knowledge of those aspects of the nuclear-energy field affecting their own responsibilities, and must be ready, where necessary, to interpret this knowledge to the general public. The WHO Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel was therefore asked to consider the subjects which should be included in the training syllabuses for medical public health officers and other professional public health workers, to determine what degree of knowledge the various members of the public health team should possess, and to indicate suitable methods of providing instruction for personnel who have finished their formal training and are already in service.

In the introductory pages of its *Fourth Report* the Committee discusses the problems of measuring radiation and of elucidating its biological effects. The public health aspects of peacefully used nuclear energy are then considered in their implications for the community; they are analysed as:

(*a*) Positive aspects (i.e. diagnosis, and therapy with radio-active substances; tracer uses of isotopes in biology, medicine, industry and agronomy; food and drug preservation and sterilization);

(*b*) Negative aspects (i.e. protection from the routine hazards of radiation in medicine and industry; precautions against reactor accidents; disposal of radio-active effluents); and

(*c*) Public health legislation on the control of such hazards.

The Committee summarizes the responsibilities, in relation to the use of nuclear energy, of personnel

in the various health disciplines—health officers, hospital administrators, industrial hygiene workers, sanitary engineers of all types, veterinary public health workers and laboratory and other technical personnel. The participants felt that instruction in the field of nuclear energy should speedily be incorporated in graduate and post-graduate courses for public health students. To guide those charged with arranging such instruction, they suggested that the teaching content of the courses should cover physical principles, biological principles, the application of nuclear energy and radiation, hazards and protection. Each of these subjects is considered at 4 teaching levels—an orientation course, an introductory course, an advanced course and a specialist course. The compilation of a handbook of radiological health data, to serve as a reference manual for public health workers, was also proposed.

The *Report* contains several informative *Annexures* enlarging on procedures mentioned in the text, and a glossary of simplified definitions of technical terms used.

POLIOMYELITIS

Expert Committee on Poliomyelitis: *Second Report*. World Health Organization: Technical Report Series, 1958, No. 145. (Pp. 83. 3s. 6d.). Pretoria: Van Schaik's Bookstore (Pty.) Ltd., P.O. Box 724.

The second report of the Expert Committee on Poliomyelitis reviews the poliomyelitis situation over the last three years and notes a change of pattern in the incidence of the disease. Whilst several countries which had previously suffered little from the disease reported an increased number of cases, others reported a notable reduction, attributed in most, but not in all, to mass immunization with Salk vaccine or with other vaccines of the inactivated type. Evidence is accumulating that the use of such vaccines has had a considerable effect in reducing the incidence of paralysis. However, in the United States of America and South Africa it was noted that vaccination did not apparently shorten the course of an epidemic, and studies have revealed that it neither prevented infection nor interfered with the dissemination of the virus.

The report also deals with the preparation and testing of vaccines, design of vaccination programmes, immunity surveys, the WHO Poliomyelitis Programme, live virus vaccines and the problems raised by enteric viruses.

The importance of filtration in ensuring a safe vaccine product is emphasized, and evidence based on experiments by the United States Technical Committee clearly shows that more consistent results are obtained with filtration through Seitz filters than through fritted glass filters. It is pointed out, however, that repeated filtrations resulted in considerable loss of immunogenic potency. Some producers have therefore adopted other procedures to ensure consistent safety and potency, such as double inactivation with additional chemical or physical agents without filtration. The report stresses the desirability of using for vaccine production strains of low virulence provided these are of high immunogenic potency.

Antigenicity tests on the monkey have not been found to be entirely satisfactory, and further studies of other tests are recommended, including those using guinea-pigs and chicks, together with comparative studies on children lacking antibodies to all three types of poliovirus.

The Committee emphasized the importance in any vaccination programme of giving relative priority to selected groups. These will generally, but not always, be the age-groups showing the highest incidence. Guidance is given on the other aspects of immunization programmes.

The report reviews the results of immunity surveys. These are recognized as useful or even essential under certain circumstances, but generally are regarded as a poor substitute for proper reporting of paralytic cases. It was recommended that the WHO Poliomyelitis Programme based on the designation of WHO Regional Laboratories should be extended to bring national laboratories into co-operation, the Regional Laboratories maintaining their functions as reference laboratories.

An important recommendation made is that live attenuated virus vaccines should be subjected to more extensive and carefully designed field trials. Great hopes were expressed regarding the potential value of such vaccines. The Committee also considered for the first time the problems raised by the numerous recently discovered enteric viruses, some of which are common cases of aseptic meningitis indistinguishable from non-paralytic poliomyelitis. It was recommended, therefore, that in poliomyelitis reporting, paralytic cases should be reported separately and that the term aseptic meningitis should be used in place of the term non-paralytic poliomyelitis.

A considerable amount of detailed information on laboratory techniques is given in the 5 Annexures which complete this report.

HOSPITALS AND COMMUNITY HEALTH

Role of Hospitals in Programmes of Community Health Protection: *First Report of the Expert Committee on Organization of Medical Care*. World Health Organization: Technical Report Series, 1957, No. 122; 34 pages. 1s. 9d. Pretoria: Van Schaik's Bookstore (Pty.) Ltd., P.O. Box 724.

The promotion of health is no longer concerned only with the control of pathogenic dangers, but also with the maintenance of the physical, mental and social well-being of all members of society. Hitherto the role of the hospital has been restricted to the treatment of diseases and injuries, but the time has come to widen its scope. The Expert Committee on Organization of Medical Care considers, in its report, how the hospital can provide the population with complete health care, both curative and preventive, and also be a centre for the training of health workers and for bio-social research.

The hospital must not be an isolated institution: it must fit into the general health programme and seek to gain the full support of the population by every available means.

It is by regionalizing the hospital system, i.e. by establishing around central hospitals a network of intermediate and local hospitals and health centres, that hospital resources can best be adapted to the needs of the community. Every general hospital should have a sizable out-patient department, providing consultation services and home medical care, through which it can reach out to the family unit. The concepts of 'day hospital' and 'night hostel' have recently been introduced. At the day hospital

patients can receive the necessary treatment and return home in the evening. The night hostel receives patients who are able to work during the day, but whose home conditions might aggravate their illness or make treatment impossible.

With regard to administration, the Committee considered it preferable for a physician to be in charge of a hospital. Nurses and medico-social workers will be called upon to perform an increasingly important role in hospital teams, while general practitioners and public health officers must also play their part in hospital activities.

In brief, the general hospital should be so planned as to provide medico-social institutions, public health administrations and individual practitioners with material support and with a means of achieving over-all co-ordination.

DRUG ADDICTION

Expert Committee on Addiction-Producing Drugs: Eighth Report. World Health Organization: Technical Report Series, 1958, No. 142; 12 pages. 1s. 9d., Pretoria: Van Schaik's Bookstore (Pty.) Ltd., P.O. Box 724.

One of the tasks of the *Expert Committee on Addiction-Producing Drugs* is to advise the *Commission on Narcotic Drugs* of the *Economic and Social Council of the United Nations* on the medical aspects of narcotic drug control. The situation is periodically reviewed in the Committee's *Reports*, which include technical information on drugs having addiction-producing properties.

In its eighth *Report* the Expert Committee reviewed the present situation with regard to the actual or potential danger to public health represented by the liability of certain drugs to produce addiction. Whereas the Committee advised that the present status of control be continued for dextromethadone, propoxyphene and the cough mixture *Ticarda* (containing normethadone), it recommended that the recently developed analgesic dextromoramide (R 875) as well as a number of pethidine derivatives —morpheridine, trimeperidine and etoxeridine— should be subjected to the same control measures as apply to morphine.

In connexion with the introduction of new drugs, particularly those that are a potential hazard to public health owing to their inherent addiction liability, the Committee stressed the need for adequate information to be supplied to the medical profession. The Committee reiterated its view that heroin can be dispensed with as a therapeutic agent, emphasizing the availability of suitable substitutes. With a view to the development of non-addicting drugs with analgesic effect comparable to that of morphine, the *Report* refers to the discovery of the analgesic properties of nalorphine, the utilization of which as a tool for the diagnosis of drug addiction is also dealt with.

Amongst other items relating to drug addiction and addiction-producing drugs, the *Report* reviews the development of methods for the evaluation of addiction liability, the present situation with regard to the misuse of tranquilizing drugs, the progress made in the selection of international non-proprietary names for drugs under international narcotics control, and the question of outmoded preparations at present exempted from international narcotics control.

CORRESPONDENCE

SAFETY SEAT BELTS IN THE PREVENTION OF TRAFFIC INJURIES

To the Editor: Your timely Editorial on *Safety Seat Belts in the Prevention of Injuries in Traffic Accidents* in your issue of 2 May, prompts me to remind your readers that in May 1958, there was a 3-day conference on automobile safety and automobile crash injuries at Ann Arbor, Michigan.

It was held as part of the Medical Education for National Defense Program, and was attended by representatives of most American Schools.

At this meeting it was shown statistically that a passenger is 3½ times as safe from accidental death or severe injury if he is wearing a well-designed and fitted safety belt at the time of the car accident.

If a car travelling at 60 m.p.h. comes to an instantaneous stop in a collision with a massive object, the passenger in the front seat decelerates at 1,936 feet per second per second for a distance of 2 feet until he hits the windscreen and dashboard with a force of—

$$\text{Force in Pounds} = \frac{\text{Weight in Pounds} \times \text{Rate of Retardation in Feet per Second per Second}}{g \text{ (Being Acceleration due to Earth Gravity in Feet per Second per Second}}$$

$$= \frac{200 \times 1{,}936}{32}$$

$$= 12{,}100 \text{ lb. or } 6 \text{ tons.}$$

He travels the 2 feet in 0.0455 second.

The decelerating force = 60.5 times the gravitational pull of the earth on the man's bodyweight, i.e. 60.5 g.

The unfortunate driver, however, has a shorter distance, say one foot, to decelerate at 3,872 feet per second per second and only has 0.0227 second in which to achieve complete rest. If he does so by expending all the energy in impaling himself on the steering column, the pressure on the 10 square inches of the top of the column and on his thoracic cage is 24,200 lb. or 1¼ ton per square inch on the surface in contact.

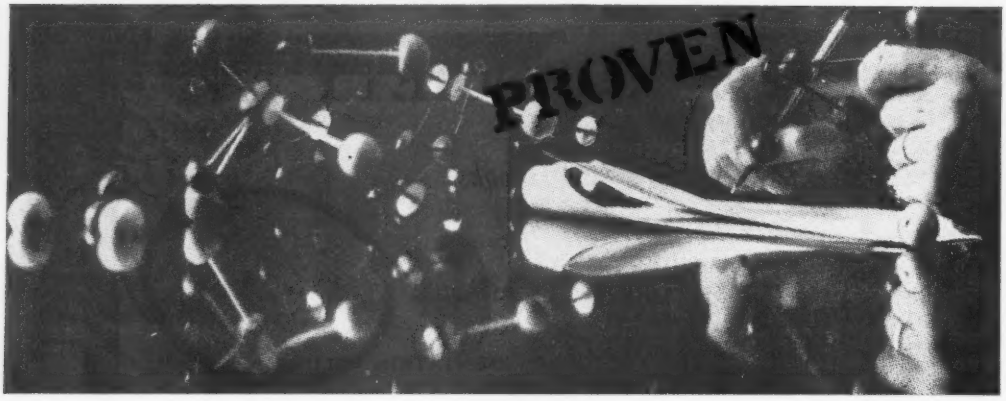
Fortunately 60% of traffic accidents occur at under 49 miles an hour and, in the majority of accidents, the car is struck a glancing blow or the car is slowed down by hard braking before the crash, so that the force to be combated by safety belts is reduced to levels where it can be successfully combated by belts designed to stand at least 20 g, i.e. a load of 3,000 lb. for a person weighing 150 lb. The human body can be safely decelerated by being subjected to up to about 27 g. Hence the value of safety belts.

The chances of being seriously injured in falling out are 5½ times greater than when the passenger remains in the car.

In that respect, therefore, safety belts are also amply justified.

G. T. du Toit, F.R.C.S. (Eng.).

Clarendon Centre Bldg.,
Park Lane, Parktown,
Johannesburg.



In corticosteroid therapy, the vital question is whether prolonged administration will continue to suppress effectively disease activity and yet not give rise to serious side effects.

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"Triamcinolone, a new fluoroprednisone compound, has been shown to have a significant temporary suppressive effect on psoriasis . . . Triamcinolone also proved to have potent anti-inflammatory properties in the treatment of various other dermatitides"[3]
"Possesses a very high order of anti-rheumatic potency"[4]
"A potent anti-allergic compound"[5]

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[1] *Hartung, E. F.: Triamcinolone in the Treatment of Rheumatoid Arthritis. J.A.M.A. 167:8:973-976 (June 21) 1958*
[2] *Rein, C. R.: Fleischmajer, R. and Rosenthal, A.: J.A.M.A. 165:14:1821-1823 (Dec. 7) 1957*
[3] *Shelley, Walter B.: Harum, Joseph S. and Pillsbury, Donald M. The treatment of Psoriasis and other Dermatoses with Triamcinolone (Ledercort) J.A.M.A. 167:8:959-964 (June 21) 1958*
[4] *Freyberg, R. H.: Bernsen, C. A. and Hellman, L.: Arthritis and Rheumatism: 1:3:215-229, 1958*
[5] *Sherwood, H. and Cooke, R. A.: J. Allergy 28:2:97-101 (March) 1957*

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